Thesis

By

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UNIVERSITY OF IBADAN

Poverty and Wellbeing among the Elderly in Iwo of Southwestern Nigeria

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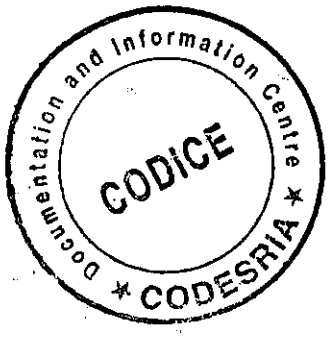
POVERTY AND WELLBEING AMONG THE ELDERLY IN IWO OF SOUTHWESTERN NIGERIA



BY

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ABSTRACT

The wellbeing of the elderly is of major concern due to their increasing proportion in African countries. The majority of elderly Africans aged 60 years and older live in poor economic conditions with little or no access to electricity, employment, housing, healthcare, safe water, refuse disposal and toilet facilities. In Nigeria the elderly constitutes more than 5% of the population. Their poor economic condition is heightened by the devastating effects of HIV/AIDs, emigration of young family members and economic crisis. There is little information on the wellbeing of the elderly living in economically constrained societies. The study, therefore, examined the link between poverty and wellbeing of the elderly in Iwo, Osun State.

Anthony Giddens' Structuration and Self-Management Ability of Aging Theories were adopted for the study. A total of 525 copies of the questionnaire were administered on Yoruba-speaking respondents at the household level in Iwo. Twenty In-Depth Interviews (IDIs) and 20 Focus Group Discussions (FGDs) were conducted among male and female elderly persons. Poverty was measured using Household Wealth Inequality Index (HWII) which determines the economic position of a particular household based on its assets, while wellbeing was assessed by WHO composite health domains namely health problems, sensory impairments, functional limitations and disability. Ethnographic summaries and content analysis were used to analyse qualitative data. Logistic regression was used to determine the dominant factors of association between poverty and health outcomes among the elderly persons.

Seventy-four percent of the respondents had limited access to less than N1000 monthly. They lived in poor housing conditions without toilet facility, electricity, safe water and garbage disposal. Twenty-six percent of them reported having hearing impairment and 22.4% had poor sight. Respondents reported having arthritis (52.9%), headaches (38.8%), fever (52.0%) and chest pain (18.4%) among other health challenges confronting them. Logistic regression results controlled for age and gender showed that the wellbeing of the elderly persons is negatively significantly related to each of the health outcomes namely health symptoms, sensory impairments, functional limitations and disability. Age groups were positively related to reporting more health problems ($\aleph^2$ =43.21, $p<0.05$). Qualitative data revealed that lack of children care, landlessness, out-migration of young family members, economic crisis were perceived determinants increasing poverty and generating health challenges among them. The FGD data further revealed that taking of herbs (*agbo & agunmu*), special meals (*aseje & agunje*), special chewing-stick (*orin-agba*), body-incision (*gbeere*) and sacrifices (ebo) were some of the cultural practices perceived as enhancing the wellbeing of the elderly persons.

Socioeconomic wellbeing of the elderly in Iwo is poor and this has affected their instrumental activities of daily living. Access to formal and informal social and economic security and health promotion strategies are needed to enable elderly persons to overcome the challenges of old age poverty and ill-health.

Key words: Ageing, Cultural practices, Health outcomes, Wealth inequality, Iwo
Word count: 457

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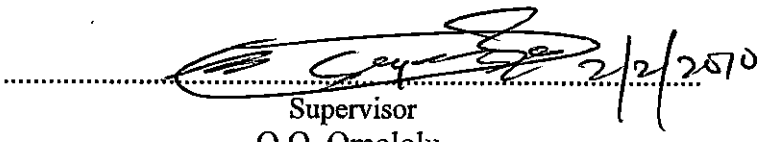
Olusegun Moses TEMILOLA, 2010

DEDICATION

This thesis is dedicated to Almighty God, whose love and protection made it possible for me to complete this work and to my parents and siblings for their understanding, support and strive for excellence.

CERTIFICATION

I certify that this work was carried out by **Mr. Olusegun Moses TEMILOLA** in the Department of Sociology, University of Ibadan, Ibadan, Nigeria



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ABBREVIATIONS

ADLs	Activities of Daily Living
AGBO	Traditional herb for treatment
ARUGBO	Elderly person
AGBO-ILE	Compound
BAALE	Elderly head of the family
DFID	Department for International Development
Ébo	Sacrifice made to appease the gods
FGDs	Focus Group Discussions
FOS	Federal Office of Statistics
HDR	Human Development Report
HAI	HelpAge International
HDI	Human Development Index
HPI	Human Poverty Index
HWII	Household Wealth Inequality Index
HIV/AIDs	Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome
IDIs	In-Depth Interviews
ILERA	Health
IADLs	Instrumental Activities of Daily Living
MDGs	Millennium Development Goals
NBS	National Bureau of Statistics
NPC	National Population Commission
NDHS	Nigeria Demographic and Health Survey
NISER	Nigeria Institute of Social and Economic Research
OECD	Organisation for Economic Cooperation and Development
ORIN-AGBA	Chewing stick for the elderly
LGA	Local Government Area
SPSS	Statistical Package for Social Sciences
PHC	Primary Health Care
PRSP	Poverty Reduction Strategy Paper
UNDP	United Nations Development Programme
UNPF	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

Poverty is not an easy concept to define. As a result, a range of definitions exist and are influenced by different disciplinary approaches and ideologies. The dominant Western definition since World War II has defined poverty in monetary terms, using levels of income or consumption to measure poverty (Grusky and Kanbur, 2006: 11) and defining the poor by a headcount of those who fall below a given income/consumption level or 'poverty line' (Lipton and Ravallion, 1993:21). However, this economic definition has been complemented in recent years by other approaches that define poverty in a more multidimensional way (Subramanian, 1997:35). These approaches include the basic needs approach, the capabilities approach and the human development approach. Their acceptance is reflected in the widespread use of the United Nations Development Programme's (UNDP) Human Development Index (HDI), which is a composite measure of three dimensions of human development: (i) life expectancy, (ii) educational attainment and (iii) standard of living, measured by income in terms of its purchasing power parity (UNDP, 2006: 263). It is also reflected in the Organisation for Economic Co-operation and Development's (OECD) conceptualisation of multidimensional poverty, defined as interlinked forms of deprivation in the economic, human, political, socio-cultural and protective spheres (OECD, 2006). Poverty is also defined by a sense of helplessness, dependence and lack of opportunities, self-confidence and self-respect on the part of the poor. Indeed, the poor themselves see powerlessness and voicelessness as key aspects of their poverty (Narayan, Chambers, Shah and Petesch, 2000). Furthermore, the acknowledgement of the multidimensionality of poverty is reflected in the range of both quantitative and qualitative methodological approaches adopted to conceptualize and measure poverty in this study.

In considering issues of poverty, ageing and old age, it is important to highlight a number of background issues forming the framework in which the elderly experience poverty. First, concepts of ageing are themselves problematic. A universally applicable definition of what constitute old age remains elusive. The ageing process itself is a biological reality but it is also subject to social constructions by which societies make

sense of old age. Chronological age, the major dividing line adopted in the developed world has far less importance in developing countries. Other socially constructed meanings of age are more significant, including the roles assigned to the elderly. It is the loss of roles accompanying physical decline or other changes in status (such as widowhood) is of significance. In many developing countries old age is seen to begin at the point when active contribution is no longer possible.

The second point in addressing the issue of poverty for the elderly in a context of rapid population ageing is the central feature of the global demographic transition, which has been gathering momentum during the second half of the twentieth century. Falling fertility and mortality rates, the late stages of demographic transition long recognised as characteristic of richer societies, have become an issue for poorer countries too. Since 1980 developing countries have been home to the majority of the world's older people, a proportion which will reach 70% by 2025 (United Nations, 2001). The rapidity of population ageing in these countries is also unprecedented. While France for example took 115 years to increase the proportion of its older population from 7% to 14% in many countries the same transition will be achieved in less than 20 years (HelpAge International, 1999).

As the most populous and one of the largest countries in Sub Saharan Africa (SSA), the issue of poverty in Nigeria is of concern not only in itself but also as a challenge for poverty reduction mandate in the whole of the African continent. Despite Nigeria's physical and human resources potential, its socio-economic and political situation has been unstable for more than two decades with adverse consequences for welfare and poverty of its population. Nigeria currently has the highest elderly population in Africa (Kinsella and Velkoff, 2001) with the largest population in Africa and the ninth in the world, it is estimated that by the year 2025 (see Table 1.1) the population of Nigerians aged 60 years and above will constitute 6 percent of the entire Nigerian population.

Table 1.1: Projected Population Ageing in Africa: From 2005-2050

	Population 60+ (percent)			**Population 60+ (millions)**		
	2005	2025	2050	2005	2025	2050
Africa	5.2	6.4	10.0	47.4	85.8	192.9
West Africa	4.7	5.5	9.0	12.0	21.8	51.6
Nigeria	4.9	6.0	9.0	6.4	11.5	25.5

Source: United Nations Population Division (2005)

There is the potential for a rapid growth rate of the elderly population in coming years, with a lower growth rate among the younger population. The implication is a major change in the age structure of Nigerian society. Based on the findings of the National Census conducted in 2006 the National Population Commission confirmed that the percentage and the number of those aged 60 years and above is increasing. Poverty is the inability to adequately meet the basic human necessities of food, clothing and shelter. It is a broad, multi-dimensional as well as a partly subjective phenomenon. It is a major challenge to socio-economic, political and technological in any given society. The crisis of poverty is manifesting in many ways, including the lack of capacity by individuals or groups to function and feed well in the society (Sen, 1981:23).

Globally about 1.2 billion people are in extreme poverty, living on less than one US dollar per day. Majority of these people are in developing countries (IFAD, 2007). The Human Development Report (UNDP, 2009) reveals Nigeria as one of the poorest among the poor countries of the world. Nigeria is ranked 114th with respect to the Human Poverty Index (HPI) making it the 20th poorest country in the world with 64.4% of the population below income poverty level. The bitter reality of the Nigerian situation is not just that poverty is getting worse by the day, but that more than 4 out of every 10 Nigerians live in conditions of poverty of less than N320 per capita per month. This would barely provide for a quarter of the nutritional requirements for healthy living (Afonja and Ogwumike, 2003).

Despite the huge resources, poverty is widespread in Nigeria (see Tables 1.2 and 1.3). Poverty statistics showed that poverty level rose from 28.1 percent of the population in 1980 to 46.3, 65.6 and 68.7 percent in 1985, 1996 and 2004 respectively. In absolute terms, the numbers of poor people in Nigeria has increased four folds between 1980 and 1996 (FOS, 1999). The poverty situation in Nigeria worsened since the late 1980s and the country is classified among the 20 poorest countries in the world (IFAD, 2007). A significant proportion of Nigeria's population lives in poverty. Approximately 70 million people live on less than US$1/day (World Bank and DFID, 2005: 8), 54% of Nigerians live below the poverty line (UNDP, 2006a) and over one third live in extreme poverty (defined as those who cannot afford 2,900 calories per day) (UNDP, 2006b). Poverty has increased in recent decades: between 1970 and 2000, those living on less than US$1/day

increased from around 36% to around 70%, translating into a real increase in the number of people living in poverty from 19 million in 1970 to 90 million in 2000 (Sala-i-Martin and Subramanian, 2003:4). Human development indicators are also poor: Nigeria's Human Development Index (HDI) was low (0.448), giving the country a ranking of 158th position out of 177 countries (UNDP, 2006a). Disaggregated figures highlight the various dimensions of poverty in Nigeria: one in five children die before the age of five; 3 million people are living with HIV/AIDS; and 7 million children are not attending school (DFID, 2007).

Sala-i-Martin and Subramanian (2003) observed that poverty in Nigeria is on the increase in that the country has experienced a sharp deterioration in income distribution; in 1970 the top 2% and the bottom 17% of the Nigerian population earned the same total amount of income, but by 2000, the top 2% had the same income as the bottom 55%. Poverty and inequality in Nigeria has strong regional concentrations, resulting in significant levels of regional disparity. As Table 1.4 shows, poverty is considerably higher in the North than the South of the country (National Bureau of Statistics, 2005:22). On the Human Development Index (HDI) Nigeria with an index of 0.391 was ranked 142 out of the 174 countries surveyed in 1998. In 2000, the HDI score was 0.433 and the country ranked 151. Nigeria increases its HDI score to 0.453 in 2003 but ranked 158 among 175 countries surveyed (UN, 2005:27). The HDI however fell again marginally to 0.448 in 2004 and the country ranked 158 out of 177 countries (UN, 2006:32). Recent Poverty Assessment Survey has shown that over 70% of the population are living below the national poverty line (FAO, 2006). The survey also revealed that poverty is especially higher in rural areas where majority of the people is resident and deriving livelihood from agriculture (NBS, 2005).

Table 1.2: Incidence of Poverty in Nigeria (1980-2004)

Year	Poverty Level	Estimated Total Population (million)	Pop. Affected by Poverty (million)
1980	28.1	65.0	17.7
1985	46.3	75.0	34.7
1992	42.7	91.5	39.2
1996	65.6	102.3	67.1
2004	54.4	126.3	68.7

Source: National Bureau Statistics (2005) Poverty Profile for Nigeria, Abuja.

The rapid declines in fertility rates and mortality rates with substantial improvement in health care systems have resulted in the growth of elderly populations around the world, and this trend is expected to continue in the coming years (UN, 2007). With the definition of an elderly persons as aged 60 years and over, the population projections of the United Nations show that the number of elderly people will increase from 672 million in 2005 to around 2 billion people in 2050 (22 percent of the world population) (UN, 2007). Particularly for the developing countries that will grow old before becoming rich, population ageing in the coming decades poses various challenges to governments' public policies for protecting the elderly. The incidence of poverty is better appreciated when the population is classified into the non-poor, moderately poor and core-poor. From the 24-year period (see Table 1.3), the non-poor declined from 72.8 percent in 1980 to 43.3 percent in 2004. The core poor, on the other hand, rose from 6.2 percent in 1980 to 22.0 percent in 2004.

Table 1.3: Poverty Headcount: Aggregate and Sectoral 1980-2004 (Nigeria)

Aggregate	Non-Poor	**Moderately Poor**	**Core Poor**
1980	72.8	21.0	6.2
1985	53.7	34.2	12.1
1992	57.3	28.9	13.9
1996	34.4	36.3	29.3
2004	43.3	32.4	22.0
Urban			
1980	82.8	14.2	3.0
1985	62.2	30.3	7.5
1992	62.5	26.8	10.7
1996	41.8	33.3	25.2
2004	56.8	27.5	15.7
Rural			
1980	71.7	21.8	6.5
1985	48.6	36.6	14.8
1992	54.0	30.2	15.8
1996	30.7	38.2	31.6
2004	36.7	36.2	27.1

Source: National Bureau Statistics (2005) Poverty Profile for Nigeria, Abuja.

Table 1.4: Incidence of Poverty by Zones, 1980-2004 (Nigeria)

Zones	1980	1985	1992	1996	2004
South South	13.2	45.7	40:8	58.2	35.1
South East	12.9	30.4	41.0	53.5	26.7
South West	13.4	38.6	43.1	60.9	43.0
North Central	32.2	50.8	46.0	64.7	67.0
North East	35.6	54.9	54.0	70.1	72.2
North West	37.7	52.1	36.5	77.5	71.1

Source: National Bureau Statistics (2005) Poverty Profile for Nigeria, Abuja.

Over the years, modernization, urbanization, industrialization and the accompanying western influence have brought changes in the social structure of families, households and societies and in the perceptions of the elderly in sub-Saharan Africa. Massive rural-urban movement of young family members, increasing emphasis on materialism, individualism and autonomy of nuclear family system have led to the elderly being increasingly neglected, uncared for and even abandoned by members of their own families and communities. In some cases, they become destitutes, who engage in public alms solicitation especially in cities (Ogunbodede, 1997; Togonu-Bickersteth, Akinnawo, Akinyode and Ayeni, 1996).

In consequence, global attention has shifted to this increasingly important phenomenon in Demography and Population studies. This first two World Assemblies on Ageing in Vienna 1982 and in Madrid 2002, the Beijing World Conference on Women in 1995 and International Year of Older Persons in 1999 made some recommendations to provide the elderly with protection, housing, environment, health and nutrition, income security and provision of care and support. It was also suggested that special studies should be carried out on the situation of the poor and handicapped elderly men and women in various societies.

In spite of these efforts and recommendations emanating from them, the field of ageing had been until recently neglected if not avoided by Nigerian sociologists (Eboyehi, 2008, Wahab 2005 and Ogunbameru, 1999). It is against this background that this investigation was designed to address issues relating to poverty and its impact on wellbeing of the elderly in Nigeria.

1.1 STATEMENT OF THE PROBLEM

The unprecedented increase in the number of the elderly worldwide will continue to be an issue throughout the 21st century, especially given the challenge of poverty today among this growing segment of the population. Current debates on ageing in Sub Saharan Africa center on a concern about the growing threat of poverty among the elderly and its impact on all aspects of their wellbeing. The deficiencies in or absence of social security system in many African countries and the weakening of the traditional role of the extended family safety net due to modernization, urbanization and changes in living standards have deleterious consequences on their financial and health status (Heslop and Gorman, 2000:47).

Despite a growing international concern, mainstream development policies in Sub Saharan Africa fail to consider poverty among the elderly. None of these programmes exclusively target the elderly, who are among the most vulnerable groups in the society. This disregard of the elderly is also mirrored in the major global poverty eradication targets – the Millennium Development Goals (MDGs) (UN, 2000). A major reason underlying this lack of attention paid to the elderly in mainstream anti-poverty efforts in African countries such as Nigeria are a set of common assumptions about the relative magnitude, severity and relevance of the poverty threat facing the elderly compared to younger age-groups. This specifically holds that younger age-groups are most affected by or vulnerable to poverty than elderly people. Also that elderly people's needs are by and large still catered for by the traditional family safety net, which traditionally is supposed to protect the elderly and that they are less important in societal terms because they still represent such a small proportion of the population and because they will contribute much less to overall development than the young (Barrientos, 2002:47).

However, there is growing evidence which highlights the vital contributions that the elderly in African societies make to the welfare of their families and this to societal development as a whole. These contributions have emerged more particularly in the context of HIV/AIDs where elderly people are shown to often act as the sole caregivers of younger ones dying or orphaned by the disease (HelpAge International, 2003). The elderly typically are among the poorest of the poor in African nations (HelpAge International, 1999:13). Their needs which include financial security and healthcare are

hardly acknowledged in poverty reduction initiatives. These have implications for their wellbeing, which on individual level determine the capacity to earn a living or participate in family and community life, as well as a sense of personal wellbeing (Lloyd-Sherlock, 2000). Nevertheless, poverty threat is facing them because of lack of research evidence and analysis on the situation and extent of poverty among the elderly. Very little is known on the linkage between old age, wellbeing and a greater vulnerability to poverty among the elderly in Nigeria and other African countries.

Indeed, most of the elderly reside in rural areas (UN, 1991) and Nigeria fits into this picture as the 1991 census results indicated that 68 percent live in the rural areas (NPC, 2006). Rural life is generally characterised by poverty and underdevelopment. These are reflected in the poor and inadequate housing structures, poor nutrition, water problems, low income levels, poor transport and communication facilities and low levels of life expectancy.

Beyond that, the some studies conducted in Nigeria (Wahab 2005, Fajemilehim, 2000 and Oyeneye, 1983) were carried out among the elderly Yorubas of Southwestern Nigeria, from social, biomedical and epidemiological perspectives. This study sought to bridge the gap in knowledge concerning poverty and its correlates on their wellbeing in the face of the current global economic and financial meltdown and weakening of the extended family ties in Nigeria.

These studies (Eboyehi, 2008; Wahab 2005; Apt 2000) have noted that family members, especially children as the major factor of old age support. But then, none of these studies has attempted an in-depth analysis using both qualitative and quantitative approach on the change dynamics within the household due to the challenges posed by rapid modernization, urbanization, industrialization, western influence, the scourge of HIV/AIDs pandemic and the recent global economic crisis, which have negative impact on the socio-economic wellbeing of the elderly.

The Nigeria Institute of Social and Economic Research Review of Nigerian Development (NISER 2000:23) reports that the number of the elderly is higher in Southern Nigeria than in the Northern states. This suggests that ageing is significantly more of a problem in the south than in the north for two main reasons. First the quest for educational and employment opportunities has led to massive out-migration of young

family members (including women who are the primary caregivers of the elderly). As more and more people move to cities, the elderly are losing traditional family support and social networks and are increasingly at risk of poverty. This aggravates their problem as they now eke out a living by themselves in the absence of children. The consequences are enormous. There is sporadic drop in financial and material resources being remitted by migrant children who themselves are struggling with their own needs, those of their immediate family and their elderly parents. Many offspring are more likely to face the problem of their immediate family when resources are scarce. The second reason is that the continuous influence of western culture on nuclear family and individualism generate social, economic and psychological problems to the extent that the elderly are now exposed to neglect and abandonment.

In line with the foregoing, some research questions are generated for this study: what are the perceived determinants of poverty in old age? What is the local understanding or conception of poverty among the elderly? What are the determinants that expose the elderly to poverty in old age? What are the health challenges facing the elderly? What is the influence of poverty on their wellbeing (health status)? What is the indigenous practices that influence their wellbeing and health behaviour? What are their coping strategies? This study attempts to address these questions so as to understand and tackle problems of poverty and health challenges among the older population in Nigeria.

1.2 OBJECTIVES OF THE STUDY

The central objective of this study is to investigate the influence of poverty on wellbeing of the elderly in Iwo community, Southwestern Nigeria. The specific objectives of the study are to:

1. Examine the level of poverty among the elderly in Iwo community.
2. Investigate the local understanding/perceptions of poverty among the elderly.
3. Identify the perceived determinants of poverty in old age among the elderly.
4. Investigate health problems facing the elderly and coping strategies in Iwo.
5. Examine the relationship between poverty and wellbeing of the elderly in Iwo.

1.3 SIGNIFICANCE OF THE STUDY

The present study is relevant in line with the recommendations of some of the World Organizations such as the 1994 Cairo International Conference on Population and Development, Beijing World Conference on Women in 1995, United Nations Conferences and the first two World Assemblies on Ageing in Vienna in 1985 and in Madrid in 2002. The recommendations included a plan of action to provide the elderly with protection, housing and environment, health and nutrition, income security and provision of care and support. The study provided useful information and contribution in this regard that addressed the needs and concerns of the Nigerian elderly.

The 1999 Nigerian Constitution Section 16(2) states *inter alia* that one of the economic objectives of the government is the provision of old age care and pensions for a suitable and adequate shelter and food. This study therefore is a right step at providing a basis for the achievement of the above fundamental objective of the government. Besides, there is the need to understand old age dimension of poverty as a pointer to the wellbeing of the elderly in Nigeria.

The study is significant because ageing is part of life, regardless of whether one views it positively or negatively. Individuals get involved in the ageing process as from the moment of birth and go through the life course accumulating a range of experiences that may positively or negatively affect their capabilities and wellbeing in later years. In the next 10 to 20 years, the demographic changes of longevity and low fertility will cause most countries to think more in support for the elderly people in fundamental ways, this is because they will make more demands on health and medical services, among others.

Furthermore, compared to the situation of elderly persons in developed countries, the living profile of their counterparts in developing countries is not well understood due to the paucity of necessary data. Although few studies related to the elderly have been conducted in Nigeria (Fajemilehin, 2000; Togonu-Bickersteth, 1999), information gathered from these surveys is not only fragmentary but also insufficient to adequately understand the status of the elderly and the nature of problems facing them with reference to poverty and wellbeing. Most of these studies were carried out mainly from biomedical or medical or psychological or epidemiological perspectives. This study is also necessary

to help in the formulation of programmes and policies that address the concerns and needs of the elderly.

Data generated from the study contributed not only to the literature on poverty, ageing, the elderly and their wellbeing but also serve to enhance conceptual and methodological development of social demography. Consequently, the study will be useful for researchers, social workers and policy makers.

1.4 SCOPE OF THE STUDY

The study describes the social and cultural context of poverty and wellbeing among the elderly in Iwo. The study is focussed on one of the most vulnerable groups in the society – the elderly. They have been singled out as experiencing deprivation because of their stage in the ageing life cycle (World Bank, 2000:23). The elderly are an important segment of the population which has special health, economic, social and emotional concerns.

The study was geographically delimited to Iwo community in Osun State, Nigeria. The study area is a Yoruba community in Southwestern Nigeria, which represents a typical Yoruba setting. The Yoruba only constitute a geopolitical zone out of the six zones in Nigeria. This implies that most of the findings could be applied to other numerous Yoruba societies across the zones and elsewhere in Africa.

The study analyses the complex relationship between poverty and the health wellbeing of the elderly using the combined strengths of quantitative and qualitative methodology; namely the questionnaire, in-depth interview and focus group discussion.

1.5 OPERATIONAL DEFINITIONS

Operationalization of concepts gives direction to a study and ensures control over the properties and characteristics of the investigated issue(s) by identifying the key variables that make up the units of analysis. The purpose of operationalization is to assign empirical and logical meanings to concepts in an explicit and precise way, such that measurability and replication of the study is possible (Hoover and Donovan, 1995).

Activities of Daily Living (ADLs) refers to the daily tasks of keeping the body and soul together such as eating, bathing, toileting, walking and the like. In other words, they are activities of upper and lower body movements.

Elderly is defined as persons aged 60 years and above (United Nations 1991, NPC 1991).

Poverty: In this study, poverty refers a state of deprivation resulting in living conditions that lie below some minimum standard of living. The measurement of poverty adopted in the study focussed on two components, which are income and non-income indicators. On income level, respondents were asked several questions in the questionnaire such as how much is your monthly income and how much do you spend daily among others While on the non-income level, it was measured by a Household Wealth Inequality Index (HWII) to determine economic position of a particular household whether the household owns or possesses a number of assets.

Wellbeing is mostly related to health, which is a state of complete physical, mental and social wellbeing, and not merely absence of disease or infirmity (The Alma-Ata Declaration 1978). In this context, the wellbeing of the elderly is herewith measured based on World Health Organization (WHO) four main domains namely; pathology (health symptoms), sensory impairment, functional limitation and disability. Each pertains to particular sets of health issues. Wellbeing and health are interchangeably applied in this study.

1.6 OUTLINE OF THE RESEARCH

The thesis is divided into five chapters. The first chapter is introductory. It presents the subject matter of the study as well as the background to the study. The section also provides an appropriate synthesis of the main focus of the study stressing that poverty in old age is a major challenge to individual and societal wellbeing and national development. Having problematized the problem of the study, research questions were raised for the investigation. The general aim of the study is decomposed into five specific objectives of the study. The significance of the study stresses that there is the need to study the sociocultural correlates in old age poverty and wellbeing (health status) of the elderly. The scope of the study and operational definitions follows in that order.

The second chapter contains the review of literatures and theoretical framework. The literature review is subdivided into sections based on the specific objectives of the study. The study utilises theoretical triangulation of Anthony Gidden's Structuration and Successful Self-management of ageing theories. The last section presents the conceptual framework which provided diagrammatic model of the two theories applied in the study.

The third chapter contains the description of the methodological steps taken in this investigation. The study is a cross-sectional survey which utilizes quantitative and qualitative methodology in data generation. The study population is basically among the elderly people aged 60 years and above. The study area is also presented here. It is a predominantly a Yoruba community. The research instruments include survey, focus group discussion (FGDs) and in-depth interviews (IDIs). The study findings were analysed using Statistical Package for the Social Sciences (SPSS), content analysis and ethnographic summaries enhanced by computer analysis. Ethical consideration and problems encountered on the field are in that order presented. Measurement of the key variables of the study is presented in the last section.

The fourth chapter contains the data presentation, analysis and discussion of findings. Data are presented in pictorial and prose methods. The pictorial method is in form of Table s and the prose method is in form of narrations – the content analysis and ethnographic summaries. The results are presented based on the objectives of the study. The discussions of the findings are also related to other relevant previous studies. This establishes a link between the discussions and the literature review of the study.

The fifth chapter presents the summary, conclusion and recommendations, policy implications and contributions to knowledge. The chapter is divided into two sections. The first contains the summary of major findings based on the study objectives. The second section presents the conclusion that poverty in old age is pervasive in the study area and remains on the high side in Iwo community. It is recommended that the concerns and needs of the elderly should be addressed at the level of household and that public and private sectors and relevant authorities should introduce pre-old age and retirement programmes early enough before attaining 60 years of age. This will be very useful in ensuring appropriate and effective management of poverty and challenges of wellbeing (health status) in old age in the community and elsewhere.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 INTRODUCTION

This chapter is divided into two major sections. In the first section, the state of knowledge on the subject matter under study is revealed through a review of relevant literature, special attention is drawn to the issue of poverty, old age poverty as this relates to their wellbeing in terms of health seeking behaviour. The section also reviews literature on ageing, elderly projections, poverty, methodological issues and determinants of poverty among others. The review is a pointer to what is known about old age poverty with its attendant health behaviour as well as what areas require more attention. As expected, this study through review draws attention to some gaps in knowledge which it seeks to fill. The second part appraises theories on poverty, its perceived determinants as well as health challenges of the elderly in the study population.

2.1 AGEING AND THE ELDERLY

The elderly represents the obvious ageing segment of the population. Ageing is a process of change from a life of independence to one of increasing dependence on others. In consequence, they become vulnerable to diseases because of their decreased physiological makeup and defence mechanisms and this influence their health and financial status in that they are less able to work and care for themselves. Put differently, it may be seen as a process of deterioration and deprivation associated with an increase in vulnerability and a decrease in income-generation ability and activity. It shows itself as a state of an increased probability of death with increasing chronological age (World Bank, 1994).

As human beings grow and consistently develop over time, they subsequently reach a peak and decline at a certain age range. Human beings decline in intellectual physical, anatomical, physiological and psychological capacities with increasing age. These changes leave the individual vulnerable to internal homeostatic imbalances or to environmental insult which may pose as a threat to the survival of the humans (Barker 1998). However there has been increased likelihood for those changes to occur later in

life of humans because of the natural age related changes in body system functioning as reported by experts in the field of medicine.

Ageing, which is the process of growing old, has been defined by Surman (1998) as a biological process along the continuum through conception (embryo/foetus), childhood (growth and development), adulthood (homeostasis) to old age (deterioration and senescence). Prior to the above, in the medieval period, Pythagoras had explained the ages of man as childhood, youth, manhood and old age (gerocomice) which is the most important of the ages. Nowadays, ageing as a concept, to some people stands as a statutory retirement age, while some attribute it to changes seen in older people, and that it is clearly associated in most people's mind with old age.

However, today ageing is widely perceived as a time of decline and loss. There are yet some cultural beliefs along with modernization, emphasis on formal education, material success and individualism that have led to a gradual erosion in power, prestige and perception of the elderly in the societies, whereby women are seen as objects of inheritance; having no rights (HelpAge International, 1999).

Ageing, under the theory of wear and tear, is defined as a process of gradual deterioration of various organs/systems necessarily for life that started right from conception (Curtis, 1966). Biological ageing has been described as a deterioration process in a decrease in viability and an increase in vulnerability (Atchley, 1981). The resultant effect shows itself as an increasing chronological age of every individual (Strecler, 1962 and Comfort, 1964). The heart, lung, nervous system, liver, kidneys and digestive system all show a loss of function as the individual ages, a result of which causes the loss of ability to withstand disease afterwards (Papper, 1973; WHO, 1993).

In most societies, old age has been equated with dependency and helplessness. This is the period that an aged person is catered for or supported by members of his or her family. However, Restrepo and Rozental (1994) note that dependency is socially created. Hence it is only within specific societies that the word 'dependency' finds its precise meaning. Once human beings are not capable of fulfilling accepted social ends, they are perceived as a burden on family members and society (Amosun and Reddy, 1997).

There is a variety of conceptions to being an elderly person. The term elderly appears both social and biological. Socially, it refers to a particular age category of

people of the society. They are the people who have attained the prescribed age of 60 years and above, which is the traditional age of retirement in Nigerian Civil Service. Biologically, the elderly is associated with changes in facial appearance and the level of physical abilities of individual members of the society.

Julian (1980) makes three classifications in this regard. The first comprises the "young old persons" – within this age brackets of 60 – 70. This group is regarded as still being healthy and active. The second group refers to as "old-old" constitutes persons between the age ranges of 71-80, who are more likely to require support. The third group, the "frail elderly" is made up of people above 80 years, who for health and economic reasons cannot fend for themselves without support.

The term 'elderly' can also be considered from three perspectives viz: psychological, physical and social. The psychological approach considers the older person's feelings, perceptions and attitudes (Rogers, 1979). This refers to the developmental stages in the emotional, cognitive and behavioural aspects of the individual's personality. Physically, old age is defined with regard to body posture, hair colour, voice and ability to see and hear, that is, body maturation or biological and physical changes in the individual over time. This is the visible aspect of the ageing process. Social ageing relates to the movement of an individual from one status to another and his experience in the course of his life and the manner in which he relates his ageing to his society (Abdulrahman, 1988).

Globally scholars and researchers, such as economists, psychologists and sociologists among others, have treated the concepts of "elderly", "aged", "old age", "older people", "retirees", "pensioners", "senior citizens" and "ageing" in different societies at different times differently. These concepts convey different ideas in different societies because of the differentials in the rate of human physical degeneration and the degree of incapacities at relatively advanced age, which results from differences in health and living conditions generally (Olusanya, 1986). Put succinctly, ageing has no univocal definition. United Nations experts prefer the term "ageing" to "elderly" or "aged" since it provides a more description of the continuing development and change during the later stages of the lifespan rather than a fixed or status period of life (United Nations, 1991).

Olusanya (1986) affirms that in Africa "aged" or "elderly" may involve intergenerational comparisons that are the depth of residential kin group such as extended family may determine which of their members can be regarded as elderly. He adds that a married couple with children and grand children might be looked upon as elderly regardless of physique. In traditional African societies, where the accurate dating of events seems to be of secondary importance to the events themselves, it is as a result of this conceptual problem that the definition of the word "aged" is not internationally accepted and consequently the lower boundary of old age has been arbitrary fixed somewhat at 60 years, but more often at 65 years. For the purpose of this study, the elderly refers to all persons, male and female aged 60 years and above. This is also justified by the fact that the retirement age in Nigeria Civil Service is 60 years (Olutayo, 1996).

Fadipe (1970) argues that in pre-colonial Nigeria society, the economic, social and emotional needs of the elderly are adequately met through the household. In his view, among the Yoruba of Southwestern Nigeria, the elderly has the last word in an argument, while his opinion or advice is taken with respect. No affront or abuse is even allowed to the elderly, whether rich or poor. In other words, the elderly is respected and given due honour. Furthermore, old age is a symbol of power and authority and many Africans are aware of this and they are careful not to appear disrespectful before an elderly person. In the traditional African societies, elderly persons are treated with awe and reverence and they are in charge of the maintenance of social order. The elderly represents the most precious asset any society can have. They represent the society's past, a guide for the present and inspiration for the future. Old age is believed to confer mystical and social privileges (Amosun and Reddy, 1997; Togonu-Bickersteth, 1986; Fadipe, 1970).

In the same vein, Sagner (2001) in a study of the Xhosa people in Southern Africa found that the elderly people were regarded as the representative of the ancestors, creators and guardians of the cultural traditions. The Xhosa view ageing as a process, which leads to an increase in experience and wisdom and to perfection of adulthood. Sagner noted that this ideological emphasis on age and seniority was bolstered by the Xhosa religious worldview.

2.2 PROJECTIONS OF THE ELDERLY POPULATION

The elderly are those aged 60 and above and poverty studies have singled them out as one of the groups experiencing deprivation because of their stage in the lifecycle (World Bank, 2000). According to Asiyanbola (2005), the elderly population is increasing in all countries of the world. This is due to several factors which include decline in fertility, improvement in public health and increase in life expectancy. Decline in fertility was brought about by more widespread acceptability of family planning while increase in life expectancy is attributed to improved medical care brought about by technological advancement. As at 1998, a published U.S Bureau Bulletin of the Census and Database on Ageing stated that the world's total population of the elderly people was growing at a rate of 1.7 percent per year. The population aged 55 years and above is increasing by 2.2 percent per year; and the number of persons aged 65 years and over, is rising by 2.8 percent annually.

The US bulletin showed 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 (2004:13) observed that already one out of every ten persons is now 60 years or above. By 2050 one out of five will be 60 years or older and by 2150, one out of three persons will be 60 years or older. Troisi also observed that the older population is ageing, that is, the oldest old (80 years or older) is the fastest growing segment – constituting 11 percent of the 60 years or older age group, is projected to grow to 19 percent by 2050.

Up till the early 1980s, the population of the elderly is increasing in all countries of the world; the demographic transition was mostly viewed as a phenomenon of the developed countries (Troisi, 2004). But as observed in the literature the great majority (two-thirds) of those over 60 years of age live in the developing world and that the proportion is increasing steadily and will reach nearly three-quarters by the 2030s. Troisi (2004) noted that already in 1985, 56.5 percent of the world's elderly lived in developing countries and this proportion is projected to reach 61.5 percent by the turn of the century and 71.9 percent by the year 2025.

The rapid growth in the number of older people worldwide has created an unprecedented global revolution. Improvements in hygiene and water supply and control

of infectious diseases during the past century have greatly reduced the risk of premature death. In consequence, the proportion of the world's population aged 60 and over is increasing more rapidly than in any previous era. In 1950, there were about 200 million people aged 60 and over throughout the world. There are now about 600 million, and by 2025, the number of people over the age of 60 is expected to reach 1.2 billion (UNDP, 2006).

For the first time in history, the majority of those who have survived childhood in all countries can expect to live past 50 years of age. Even in the world's poorest countries, those who survive the diseases of infancy and childhood have a very good chance of living to be grandparents. This suggests that the number of older people in developing countries will more than double over the next quarter century, reaching 850 million by 2025 that is 12 percent of their total population. By 2050, the proportion of older people is expected to increase to 20 percent (HelpAge International, 1999). There is the potential for a rapid growth rate of the elderly population in coming years, with a lower growth rate among the younger population. The implication is a major change in the age structure of Nigerian society. Based on the findings of the National Census conducted in 2006 the National Population Commission confirmed that the percentage and the number of those aged 60 years and above is increasing.

In Nigeria, the proportion of the aged population has been increasing (see Table 1.1). Before Nigeria independence in 1960, there was a population census conducted in 1952/53. Since independence, the country had only conducted two successful population censuses in 1963 and 1991. The total number of persons aged 50 years and above in 1952/53 was 2,448,000. In 1963 and 1991 population census the total number of persons aged 50 years and above was 3,617,000 and 8,227,782 respectively. The trend in the growth of persons in age groups 0-14 years, 15-44 years and above 45 years from 1952/53 to 1991 shows increasing growth in all age groups. It also shows increasing growth in the total number of elderly persons (Asiyanbola, 2005; NPC, 2000; FOS, 1999; Holmes and Holmes, 1995). The latest record shows that the elderly population of 60 years and above constitutes about 4.9%, which further heightens the age dependency ratio (NPC, 2009).

2.3 WHAT IS POVERTY?

There is no concise way of defining the concept of poverty, as it is a multi-dimensional issue that affects many aspects of human condition ranging from physical to moral and psychological (Ogwumike, 2002). As a result, different forms of conceiving poverty have emerged over the years. Some analysts have used the convention of regarding poverty as a function of insufficient income levels for securing basic goods and services. Poverty has also been viewed as inability of individuals to subsist and to produce for themselves as well as inability to command resources to achieve these (Sen, 1981; Amis and Rakodi, 1994). Some researchers have denoted poverty with the inability to meet basic nutritional needs (Dreze and Sen, 1990). Others such as Musgrave and Ferber (1976) have used the levels of consumption and expenditures to qualify the poor, while some like Singer (1975) view poverty in part, as a function of education and /or health: life expectancy at birth, child mortality, etc. Other development analysts see poverty in very broad terms such as being unable to meet "basic needs" – physical (food, health care, education, shelter, etc.) and non-physical (participation, identity, etc) requirement for a "meaningful life" (Streeten, 1979; Blackwood and Lynch, 1994).

Poverty is more easily recognized than defined. Hence, a universally acceptable definition of the term remains elusive. Poverty is a multi-dimensional, multi-component, socio-economic and cultural situation that transcends economic description and analysis. Being multi-dimensional, poverty takes different forms, of which three broad ones can be identified. These are physiological deprivation, social deprivation and human deprivation (Okunmadewa, 2001:2). Physiological deprivation is of two types: income/consumption (inadequate consumption of basic need goals, primarily food) and basic human need (inadequate basic need fulfilment, including nutrition, health and education). Social deprivation can be due to lack of basic capabilities to live a long and healthy life with freedom or lack of resources required for participants in customary activities (social exclusion). Human freedom deprivation is denial of rights and freedom or lack of dignity, self respect, security and justice.

Poverty as a phenomenon exists at the global, national, community, household and individual levels. At the national level, poverty represents a state of general socio-economic underdevelopment arising from poor natural resources endowment, poor

human resource endowment, low productivity, low and stagnating national income or GDP, inadequate availability of social and infrastructure facilities and services, and a general inability to provide a decent level of living for the ordinary citizens. At the household or individual level, poverty is the inability to gain access to basic necessities of life (such as food, clothing, shelter), inability to fulfil basic economic and social obligations and a general lack of self esteem. Inadequate income to meet basic needs, lack of skill or opportunity for gainful employment, lack of access to productive assets and social constraints to self improvement are some of the underlying factors in poverty (Olayemi, 1997).

The common practice is to conceptualise poverty in absolute or relative terms (Fields, 2000). Absolute poverty is the lack of adequate resources to obtain and consume a certain bundle of goods and services deemed basic. Such a bundle of goods and services would contain an objective minimum of basic necessities such as food, shelter and clothing (Odusola, 1997; Ogwumike and Odubogun, 1989). In this regard, absolute poverty is characterized by low calorie intake, poor housing conditions, inadequate health facilities, poor quality of educational facilities, low life expectancy, high infant mortality, low income, unemployment and underemployment. Using consumption as the base line, any household that spends more than a specified maximum of its income on basic needs such as food, housing, health care etc are considered as poor (FOS, 1999; Obadan, 1997; Odusola, 1997; Afonja and Ogwumike, 2003). According to Gordon et al (2003), poverty is also regarded as a condition characterized by severe deprivation of basic human needs, including food, safe water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to social services. Absolute poverty measures consider exclusively the wellbeing of those who are defined as poor, for example, child and infant mortality rates. This category of measures subsumes the headcount and the poverty gap.

Relative poverty, on the other hand, is the inability to attain a given minimum contemporary standard of living. It measures the segment of the population who are considered to be poor in relation to the incomes of the general population. In relative sense, poverty is conceptualized in terms of the standard of living that prevails in a given society. Thus, relative poverty exists where households within a given country have per

capita income of less than one-third of the average per capita of such country (World Bank, 1997). Relative poverty would occur where certain sections of a society do not have adequate income to enable them have access to some basic needs being enjoyed by other sections of such society. There is also material poverty, which is taken to imply lack of ownership and control of physical assets such as land and animal husbandry (UNDP, 1997).

Poverty can be structural or transitory, depending on how long poverty is expressed by an individual or a community. Structural (chronic) poverty is long term, persistent or permanent socioeconomic deprivations, the causes of which are largely structural and is linked to limited productive resources and lack of skills for gainful employment, while transitory poverty is temporary, transient and short term in nature and is linked to natural and man-made disasters. Transitory poverty is temporary, transient and short-term in nature while chronic poverty is a long-term, persistent poverty, the causes of which are structural (Haddad and Ahmed, 2003).

In light of the various definitions, it is important that a broad and wide definition that includes both economic and non-economic factors would be a useful means of dealing with all the facets of poverty. This informed the measure adopted in this investigation.

2.4 NIGERIAN POVERTY SITUATION

The poverty situation in Nigeria is in quantitative terms measured with the statistics from the FOS/NBS as derived from the analysis of a series of consumer expenditure surveys over a period of sixteen years, 1980-1996 till 2004. The analysis of these surveys showed that the incidence of poverty increased sharply both between 1980 and 1985 and between 1992 and 1996 and up to 2004. However, there was a decrease in poverty level between 1985 and 1992. The 19 states in existence in 1980 reported that more than half of the population was in poverty by 1985, eight of the same nineteen states had more than half of the population in poverty and by 1992, only three states were left in the group. However, by 1996 all the states except one had moved into the group of more than half of the population in poverty.

The number of poor people in Nigeria remains high. The total poverty head count rose from 27.2 percent in 1980 to 65.6 percent in 1996, an annual average increase of 8.83 percent in the 16-year period. However, between 1996 and 2004, total poverty head count declined by an annual average of 2.1 percent to 54.4 percent. Over the same period, the percentage of population in the core poor category rose from 6.2 to 29.3 percent before declining to 22.0 percent in 2004. The fact that over 50 percent to the total population is officially poor should be of major concern to policy makers. Efforts aimed at reducing poverty in Nigeria are also of great importance given the relative size of the country's population.

Although the overarching impact of some of the more recent interventions on the poverty situation cannot be objectively assessed due to data limitations, however, evidence from other national surveys tend to show some marginal improvement. For instance, the proportion of underweight children (a significant target under the MDG 1 on poverty and hunger) fell from 30.0 percent in 2004 to 25 percent in 2007 and 23.1 percent in 2008. According to the 2008 Nigeria Demographic Health Survey (NDHS), a significant improvement was also recorded in infant and under-five mortality rates. While the infant mortality rate declined from 110 deaths per 1000 live births in 2005 to 75 in 2008, under-five mortality rate fell from 197 per 1000 live births to 157 per 1000 live births during the same period. The 2007/2008 human poverty index was estimated to be 32.3 percent (NDHS, 2008).

The Nigerian situation had been made worse by the rapid population growth rate of about 2.83 percent since the 1990s giving rise to a high dependency ratio and pressure on resources in several areas. Besides, Table 2.1 below revealed the importance of the size of the household as a major determinant of poverty. It showed that male headed households are more likely to be in poverty than female headed ones. The level of poverty increased from 29.2 percent in 1980 to 66.4 percent in 1996 and declined to 58.2 percent in 2004. The female headed households however recorded a continuous increase in poverty from 26.9 percent in 1980 to 38.6 percent, 39.9 percent and 58.5 percent in 1985, 1992 and 1996 respectively and also declined to 43.5 percent in 2004. The lower rates of poverty in female headed households are due to their smaller size and the fact

that a greater percentage of household income is spent within the household than outside by the female headed households.

The Human Development Report 2009 ranked Nigeria as 114th out of the 177 countries in terms of human poverty index. All these point to the fact that poverty has serious political, economic and security consequences, which cannot be ignored. It is estimated by the UNDP (2009) that over one billion of the estimated six billion of the world population live in abject poverty and deprivation with income and consumption levels below universally defined poverty line of less than one American dollar a day. In sub-Saharan Africa, over 200 million of the population are considered poor. Of these, 55.8 million are estimated to be Nigerians.

Table 2.1: Poverty and Gender of Household Heads (in %)

Year	Male Headed (percent)	Female Headed (Percent)
1980	29.2	26.9
1985	47.3	38.6
1992	43.1	39.9
1996	66.4	58.5
2004	58.2	43.5

Source: National Bureau Statistics (2005) Poverty Profile for Nigeria, Abuja.

In this light of the above, it is not surprising that poverty has been observed to be not only high but also increasing. It is evident that the poverty situation in Nigeria is precarious not only in income poverty but also in terms of food poverty. On income poverty, the Federal Office of Statistics' (1999) report in UNDP (2004) Nigeria's Development Profile noted a worsening income inequality, while on food poverty; it stated that the proportion of the underweighted children stood at 30.7 percent in 1999. The figure for rural food poverty is 34.1 percent while that of the urban food poverty was 21.7 percent in 1999. Most families spend about two-thirds of the households' revenue on food alone, while the poorest households spend up to 90 percent of their income of food with very little remaining for health care, school fees, clothing and education.

2.5 DETERMINANTS OF POVERTY

Thoughts on appropriate conceptualization, measurement and accurate characterization of determinants of poverty have a long history. From analytical perspective, thinking about poverty can be traced back to at least to the codification of poor laws in medieval England, through to the empirical studies by Booth in London and Rowntree in York (Ajakaiye and Adeyeye, 2000:3). Conceptualization of poverty gathered fresh momentum in the 1980s. The principal innovations were five: First was the incorporation of non-monetary aspects. Second was a new interest in vulnerability and security, associated with better understanding of seasonality and of the impact of shocks. This pointed to the importance of assets as buffers and also to social relations (the moral economy, social capital). Third was the broadening of the concept to a wider construct – livelihood. Fourth was more innovative, which introduced the notion of food entitlement. Finally, the 1980s was characterised by a rapid increase in the study of gender. The debate moved from a focus on women alone to wider gender relations. Policies to empower women and redress gender poverty gap were then given enhanced attention.

It has become imperative at this juncture to argue that consequences of poverty often serve to reinforce the causes, leading to further impoverishment, thus making the causes-consequences-drivers of poverty almost a permanent chain or a vicious circle in a continuum. The following have been found to be either a cause or poverty perpetrating social phenomenon (Adewale, 2009):

2.5.1 Corruption: A major factor undermining opportunities for growth performance is the growing corruption. There is a mind-set, which pervades much 'entrepreneurial', and government / official activity that accepts manipulative and dishonest methods as normal. It is a problem associated with private investment, along with donor funds and public expenditures. It is endemic both in major abuse of public office and in the petty corruption within and around regular service provision. Despite apparent commitment by some governments to tackle the issue, it is proving very difficult to undermine. Again, consistent allocation of scarce national resources to less priority areas, which often decreases expenditure on vital socio-economic resources, will continue to serve a significant driver of

poverty. This wrong economic decision often lead to debt burden, insufficient resources to enhance production of food, leading to scarcity and livelihood crisis, as well as the new energy crisis.

2.5.2 **HIV/AIDs:** At the beginning of the new millennium about 40 million were estimated to have been infected with HIV/AIDs, and 28 million had already died of the disease. The number of people infected is likely to reach 100million [cumulatively] by 2010 if a massive response does not take effect immediately [UNAIDs June 2000]. The HIV/AIDs epidemic is deepening and spreading poverty, reversing human development, worsening gender inequalities, eroding the capacity of governments to provide essential services, reducing labour productivity, and hampering pro-poor growth [UNDP,2000]. Several factors have been noted to be contributing to the spread of the epidemic. These include poverty, gender inequality, intergenerational sex, illiteracy, stigma and discrimination, alcohol abuse and lack of communication about HIV and AIDS due to cultural barriers. The devastating impact of the pandemic continues to be felt at all levels of society. The overall effect also continues to be reflected in the demographic structure of the population, with life expectancy dropping significantly to around 40 - 50 years, child and adult mortality rising and the number of orphans continuing to increase at an unprecedented rate [UNDP, 2000]. Apart from a significant decline in the labour force, there will be a younger, ill-qualified and inexperienced pool of human resources in the labour market. This is due to the fact that most HIV and AIDS victims are educated, skilled and enterprising and require long periods of training and skill acquisition.

2.5.3 **Landlessness & Restricted Access to Agro-based Activities**: Inadequate physical assets, such as land caused by the absence of land reform, which would give land users the opportunity to establish legal or traditional tenure rights and give the landless poor access to land through redistribution policies (Human Rights Watch, 2001).

2.5.4 **Lack of Access to Credit Facility:** Closely complementing the above as poverty driver is the lack of provision of credit for the poor to successfully engage in income generation and self-reliant activities. The poor are denied, [for not being credit-worthy, excessive paper work, long waiting period and corruption] of access to credit to finance their small-scale enterprises and farming activities that generate employment and income, and enhance household food security. Apart from lack of adequate capital assets, the rates of return on the physical, human and social capital of the poor are generally low due to low physical productivity and low prices for their goods and services, which are the by-products of: (i) Inefficient use and management of scarce capital assets as defined above;(ii)Unequal economic power between the rich and the poor within their countries and between their countries and rich states, both of which work to the disadvantage of the poor who have little control over the determination of the prices of their goods and services;(iii)Limited economic opportunities characterized by small domestic markets for goods and services and lack of avenues for productive paid-and self-employment; and (iv) Climate change and desertification, soil erosion and degradation, water pollution and scarcity, and depletion of forests and other natural resources caused by inappropriate agricultural practices, urban development and growth of population.

2.5.5 **Social Problems:** These include violent crime, drug, murders, child/human trafficking, absentee fatherhood/single parenting, alcoholism on the part of both gender, and teenage pregnancy: The impact that violence has is enormous and is no less a contributor to impoverishment in Nigeria. The Niger delta is a good case in point. Wars, violent crime, domestic abuse especially on women and children and the elderly and substance abuse related violence have had devastating effects. Violence and alcohol-induced road accidents is one of the major causes of both mortality and morbidity. In addition to those that have died many still bare the physical and psychological scars of violence and road fatalities/injuries. The immense social and personal cost is matched by financial toll it takes, measured by the extent to which it is draining the health budget of the states, and the capacity of those affected to create wealth. Closely associated is the common

practice of early marriage and teenage motherhood which perpetuates poverty. In addition to dropping out of school, the situation gets complicated by the HIV/AIDS epidemic, with young people being the group that is increasingly affected.

2.5.6 **Political Instability/Civil Conflict & Bad Governance:** Politically, the poor are the victims of bad governance reflected in: [i] unequal distribution of political power which has left the poor voiceless and powerless; [ii] corruption which wastes and diverts resources from activities that promote the interests of the poor; [iii] lack of transparency and accountability which has the same effects as corruption; and [iv] inefficient bureaucracies which do not promote the interests of the poor. Human development and good governance are strongly related.

2.5.7 **Negative Impacts of Structural Adjustment Program (SAP):** Over the past two decades, in several countries the poor have been particularly adversely affected by the effects of structural adjustment measures/programs, such as: [i]Removal of agricultural input subsidies which have resulted in an increase in the cost of production; [ii]Privatization of state marketing corporations which has led to the closure of some of the markets that serves the poor; [iii]Retrenchments which have led to unemployment; [iv]Currency devaluations which have led to a marked increase in domestic prices of inputs and final products; [v]Liberalization of interest rate determination which has led to a marked increase in the interest rates at which the poor borrow money from financial institutions; and [v]Decontrol of maximum product prices, which has led to a sharp increase in prices.

2.5.8 **Unemployment**: Inadequate access to employment opportunities, which results from geographical isolation of the poor, low saving rate, low domestic investment, and a pattern of growth that does not generate large enough increases in employment opportunities for the poor. Employment levels and labour productivity trends in the region are generally low. The use of capital-intensive techniques of production in some sectors of the economy that have the potential for employment generation has further aggravated the unemployment problem. As

a consequence, a large proportion of the growing labour force is absorbed in the informal sector, which currently is characterized by low levels of incomes and underemployment. The youth, women and the elderly are the most affected by unemployment and underemployment.

2.5.9a Unfavourable International Terms of Trade: Domestic policies, central as they are, are not the only factors that determine the capacity to generate resources needed for rapid accumulation and the eradication of poverty. These also depend on external constraints and support. Given their structural weakness, the small size of their domestic markets and dependence on imports for capacity utilization and accumulation, such countries continue to face significant trade barriers in their more affluent trading partners (UNCTAD, 2002). Available data on the terms of trade show that most of African States have been experiencing a long-term decline in their terms of trade. This trend has been particularly persistent between 1980 and 2000.

2.5.9b Women Impoverishment and Disempowerment: Colonial policies which forbade African women from moving freely into the cities ensured an immense pool of free labour in rural areas, which made the migration system work. Buttressed by an ancient African patriarchy which defined women as male property within family and household structures, the colonial state extends patriarchal control over African women through a combination of various legal and cultural mechanisms. Socially, the poor are subject to norms, values and customary practices that disadvantage women and other groups economically, socially and politically or lead to their exclusion and powerlessness. These norms and values include: [i] Socio-economic stratifications where women are not valued as much as men; [ii] Inequitable and oppressive social relations concerning gender; and [iii] Large families, which overburden women. Although increasing attention has been given to women's issues through activism, women's demand for land, legal protection, and assured bodily integrity, recognition of their personhood in the legal and judicial systems, economic and property entitlements, and participation in decision making remain unmet. In light of the above, this present study attempts to further advance the body of literature by examining the determinants of poverty in old age among the elderly.

2.6 POVERTY AND METHODOLOGICAL ISSUES

Poverty is a multifaceted concept, which manifests itself in different forms depending on the nature and extent of human deprivation. There are perhaps as many definitions of poverty as there are researchers. At the Nigeria Economic Society Conference of "Poverty in Nigeria" in 1975, many of the papers conceived of poverty as existing when incomes or disposable resources are inadequate to support a minimum standard of decent living (Edozen, 1975; Essang, 1975). Some elements of this minimum standard approach can be seen in the other papers at the conference including Mabogunje (1975) and Onimode (1975). Similarly, Ogwumike (1991) defined poverty as a household's inability to provide sufficient income to satisfy its needs for food, shelter, education, clothing and transportation. He then noted that minimum standards for food are based on nutritional requirements in terms of calories and proteins, consumption habits and customs. As for non-food items such as shelter and education, standards such as number of persons per room and number of children receiving education or level of education attained respectively are frequently used. Ogwumike (1991) then argued that the adoption of absolute or relative standards in the determination of minimum incomes or disposable resources is what distinguishes absolute from relative concepts of poverty.

In an extensive review of the literature on poverty, Hagenaars (1991) has categorized existing definitions of poverty into three, namely those based on income, those on consumption and those based on welfare:

a) Definitions Based on Income

According to Hagernaars (1991), income may be used to define poverty because it reflects the budget restrictions within which a household can choose its consumption goods. It is also a good yardstick since it is measured on a cardinal scale thereby allowing both the incidence of poverty and the extent of poverty to be measured and compared over households. The problem here is deciding what income to use. Should it be actual cash household income? Should it be current rather than lifetime income? Should it be actual rather than potential or full income? Should it be cash income rather than the sum of cash and non-cash income?

In defining whether a household is poor or non-poor, definitions based on incomes can hardly suffice for many developing countries. In the first place, it ignores

self employment in the informal sector in studies done in many developing countries around the world (Abumere, 1999). The informal sector accounted for between 35% and 80% of total employment and more than 30% of total earnings. Any definition then which ignores earnings from the informal sector will not be helpful. Secondly an income based definition of poverty often ignores income in kind as well as "do-it-yourself" activities at home. Thirdly it neglects access to environmental resources and the variety of strategies other than income earning that households adopt in pursuit of an adequate livelihood. Environmental resources in this connection refer to all forms of resources and facilities provided by or within a nation and include piped-borne water, health and educational facilities, social and environmental service and recreational opportunities.

Lastly, it ignores vital demographic variables such as age, sex, marital status, size of family, life expectancy, infant and child mortality, morbidity and nutritional status. Aboyade (1975) has argued that since poverty is a state of inadequate command over or inadequate access to, resources to satisfy wants which are considered normal by the value system of a given society, then we much include receipts from all sources. This can help solve many of the problems based definition above.

b) **Definitions Based on Consumption**

Hagenaars (1991) has made the point that several poverty definitions are directly or indirectly based on the cost of consumption of some specific goods. Poverty, in these cases, is usually defined as the minimum amount necessary to meet "basic needs". The difficulties of Operationalization and measurement in this type of definition are well recognised in the literature. For instance, what needs are to be considered "basic needs". How should the cost of the basic needs be calculated? As Marshall (1920) and Hagenaars (1991) have quite rightly pointed out, the concept of basic needs assumes that there is a hierarchy of needs of which only the lower end should concern poverty researchers.

Considerable attention has been devoted to this concept of basic needs in the literature. In his contribution, Dudley (1975) emphasized the need for personal growth including the needs for food, clothing, shelter, education, health, work and mobility. In some studies (Abumere, 1999, Ogwumike 1989) the list is extended to include "publicly and privately" provided goods and services including public transportation, access to information and portable water, etc. Hagenaars (1991) reckons that the choice of certain

needs as "basic" reflects an absolute interpretation of poverty since it is then defined as a relative deprivation in the consumption of goods and services. Hence define somebody to be poor when the consumption pattern falls short of the general standard in the society. In this case, a hierarchy of needs is no longer applicable since it assumes that the really "basic needs" are met by everybody in society and so attention should shift from absolute to relative poverty.

What comes out in all these is that basic needs differ from place to place and from culture to culture. In recognition of this, Ogwumike (1989) has attempted to identify basic needs of Nigerians bearing in mind the customs and consumption patterns of Nigerians. The role which geography, religion, customs and traditions play in influencing choice of basic needs deserves attention.

c) **Definitions Based on Welfare**

Definitions based on welfare are few in literature. Many of them are very subjective indeed which perhaps explains their unpopularity. The welfare approach attempts to define poverty in terms of the minimum amount needed "to get along". According to Hagenaars (1991), "to get along" is a description of a welfare level. Apart from its subjective nature, other criticisms have been levelled against the welfare approach. For instance, Sen (1985) noted that the evaluation is influenced by social roles and past experience which may blur assessment of poverty levels. For instance, a lower poverty level found for women and the elderly than for men and the young probably reflects social roles and aspirations rather than actual need.

In any attempt to measure poverty levels, numerous methodological problems crop up. According to Rakodi (1995), these include variations in the size and composition of households, the difficulty of estimating income levels in Economics which are only partly monetised and in which households consume their own production, how to deal with the fact that consumption generally exceeds income and the selection of appropriate deflators, the problems that the composition of consumption differs between income groups and the real costs of different goods charged at different rates, the problems that calorie requirements, including food preferences, are culturally influenced and biologically determined and that people may be able to adapt to food shortages. In addition, there is the fact that measuring incomes in the informal sector is notoriously

difficult. Again, what do we do about transfer payments of various kinds to households? Given all these problems, Tendulkar (1992:23) reckons that "there exists an unavoidable and inherent element of arbitrariness in the specification of the poverty norm". The problems above have not deterred researchers from measuring poverty. Many methods exist in the literature. Since it has been already argued that measurements of poverty derive directly from the definitions adopted, this study adopted income and non-income measures of poverty among the elderly.

The measurement of poverty among the elderly poses some additional relevant problems. The first one is related to the lack of income data. Some older people may be living on the assets they accumulated during their lifetimes. The sale of an asset is not usually included as current income, and then not considered in a poverty analysis. While this could be the proper practice for, say, a young adult that sells his car to later buy a new one, it might be incorrect for an older person who periodically sells assets to keep his/her living standard.

An additional problem is posed by the fact that resources may be unevenly allocated within households. The typical information included in an income-based household survey does not allow identifying the specific allocation scheme adopted by each household. Another relevant problem arises from the fact that older people usually live in households with a significantly different demographic structure than the rest of the population. That difference makes the poverty comparisons between the elderly and the non-elderly population highly dependent on the assumptions about the impact of the household structure on individual well-beings. In particular, older people tend to live in households of smaller size, which impedes them taking advantage of the household consumption economies of scale.

Although it is recognised that poverty is a multidimensional complex problem, data limitations and most of the literature simply consider the poor elderly as those individuals living in households whose per capita income is lower than a certain international poverty line in terms of dollars. Most researchers and practitioners seem to agree that this is a reasonable approximation to a complex problem (Gasparini *et al*, 2007). This study did not intend to enter into the debate on the best measure. However, the methodology adopted combined the income and non-income components to measure

their economic and health wellbeing of the elderly. This is preferred to income because literature has shown that income only as a measure of wellbeing especially in Sub-Saharan Africa has many flaws (Datt and Jolliffe, 1999:217). One of the basic reasons is that individuals are often reluctant to declare their true income.

2.7 HEALTH / WELLBEING OF THE ELDERLY

Health, according to the WHO, is the state of complete physical, mental, and social wellbeing of an individual and not merely the absence of disease or infirmity (WHO, UNICEF, 1978). The definition shows that health is more than absence of disease and that it also includes the psychological dimensions which necessitate that man must be in a state of homeostasis. Beside the WHO definition, several other definitions of health also exist based on people's varying orientations. For instance, Hubley (2004) noted that the Yoruba generic concept for health is *Alafia* in its literal sense, means peace. The word embraces the totality of an individual's psychological and spiritual wellbeing in the total environmental setting. This study however argues that the concept of health is better captured as *Ilera*; meaning total wellbeing or healthiness.

Hubley (2004) also reported that the Yoruba belief that possession of *Alafia* is a result of the dynamic interaction of all those identified variables. Some of the orientations of the people include feeling orientation, diseases orientation and performance orientation. With feeling orientation, when an individual is "feeling good" then such an individual is taken to be healthy. Individuals consider the way they feel at a point in time to describe their health status. In happiness and whey they are successful in activities like business or competitive activities, they tend to feel good and thereby relate it with healthy living. Once a known and visible disease is not traced in people's body, they take it to be synonymous to healthy living. However, an individual may not be ill even though there is disease in the body. Healthiness goes beyond the absence of disease in the body and not all who do not have diseases in the body are healthy. The Performance orientation views health as "ability to perform activities". Once an individual is able to perform certain activities, then it is taken to mean healthiness. This may not hold in all situations.

In reality, the "orientations" definitions do not hold because an individual may pretend to be feeling good whereas the preference is a mechanism to avoid being

stigmatized or be seen by others as feeling bad, or may even have negative interactions with significant others, a source of unhealthiness. There may also be absence of disease in an individual but such an individual may be financially handicapped and therefore not be able to carry out some of the productive roles in the household. On the other hand, people may be mentally disturbed. Based on this inadequacy of the "orientation approaches" one may find the definition given by the WHO as all encompassing especially when it addresses the key pertinent issues; including maintenance of body and physical balance, emotional balance and social balance within oneself and with the significant others. In recent times, other new variables like spiritual balance have been included.

Natural events like floods, earthquakes and in the natural process of growing older the human body becomes weaker and is more likely to suffer from illness. There are also man-made environmental factors like unguarded cooking fires, overcrowded houses, open gutters, broken bottles, sharp objects and poorly constructed roads and buildings which can lead to accidents. However, according to Hubley (2004) even when these factors are present in the environment, people are not always injured and do not always become ill of they know how to deal with them.

The WHO's definition of health has also been criticised on the ground that the conditions of state of health is difficult to meet, and therefore a healthy state is seen as a mirage, not realistic for an individual to have a healthy state is difficult to achieve, Primary Health Care (PHC) philosophy was recommended as a driving force (WHO, UNICEF, 1978). PHC is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitute the first element of a continuing health care process (WHO, 1988).

Alakija (2000) identified key elements for the management of health. Originally there were eight elements of PHC, each one depends on the community's priority, and community needs, available resources, socio-economic and health development. These elements include promotive, preventive and curative services. Rehabilitative services are not included in the eight elements but this can be added depending on priorities and needs. In recent time, community mental health and oral health have also been added.

The eight elements of PHC include promotive which further comprises health promotion, promotion of food supply and good nutrition and provision of comprehensive material and child health including family planning. Preventive elements include the immunization of children against major communicable diseases, provision of adequate supply of water and basic sanitation and prevention and control of locally endemic diseases.

Finally curative elements among others consist of appropriate treatment for common diseases and injuries and provision of essential drugs. A critical analysis of these elements shows that reproductive roles including household production of health constitute the bedrock of PHC.

In developing nations, where there is increasing older population living in a precarious situation leading to their poor health condition resulting from diseases and respiratory infections. A combination of these poor conditions can lead to stunting and failure to achieve mental and physical potential (Hubley, 2004). The behaviour of individuals is important in the maintenance of a healthy state. For instance, washing hands and plates with soap and clean water kills some bacteria that can cause disease, using mosquito nets and insects sprays help to keep disease-carrying mosquitoes away (WHO, 1988).

The influence of culture on health is indispensable, great value is placed on the health of individuals within the sociocultural context (Hubley, 2004). Scholars have described health as a relative term and they see it as culture-bound thus cosmopolitans who are exposed and live in urban areas and probably educated are sensitive to their health as against the way of life of the rural dwellers with little or no formal education. Hubley (2004) noted that the concept of "health" is determined by culture and society and people may have different ideas about what it means to be healthy. It was also noted that traditional ideas of health in Asian, African and European cultures have a wider holistic views and termed health as: a feeling of wellbeing; opportunity of achieving fulfilling activities; a balance of physical and mental states; achievement of one's potential or ability to cope with life's demands. Among the different ways in culture can influence health as identifies by Hubley (2004) are through life cycle, patterns of living and

consumption, health and illness behaviours, patterns of communication and religion and "worldview" among others.

A growing body of evidence shows that health problems among the elderly are diet related and nutritionally dependent (Wahlqvist and Kouris, 1990). To this end, the need for descriptive study of food and health among the elderly was identified about eight years after (ACC/SCN News, 1998) and the study was not only aimed to document traditional food habits and beliefs but to predict health and survival outcomes amongst them. The importance of food pattern study helps to have a broad sociocultural approach to food and health.

Food consumption pattern looks into social, economic and environmental aspects of food and eating patterns. The food pattern is culture-specific and could be related to health status (WHO, 1995). It acknowledges excess, deficiency or their combination in food intake. The food pattern of individual can be positive and as such, encourage enjoyment of appropriate dietary intake; it helps to reflect human dietary needs that cannot be measured in numerical terms (Wahlqvist and Kouris, 1990).

The New York Times of October 10, 1992 reports "the extent of malnutrition among the elderly in general is a murky battleground for their advocates, public health officials and nutritional scientists. While some nutritionists estimate that 50% of all elderly Americans open themselves up to a host of diseases by not eating enough of the foods they need very little is known about the problem". At this period, it is appropriate to investigate the nutritional problems of the elderly because their population in most countries is growing at a rapid rate. Everybody will be in this age group one day. Research showed that the world is reaching the maximum in terms of life span and the chances of extension of life by various means including nutrition are limited (Lohman 1992).

The challenge to meet the needs of a growing and healthier population of the elderly (aged 60 years and above) requires a consideration of the provision of an adequate and sufficient nutrition, which is paramount in maintaining their functional capacity (WHO 1988). This will enable them to lead independent lives in their own families and communities. Independent living depends on being able to do the things you want to do when you want to do them according to Canada's Physical Activity Guide to Healthy

Active Living for Older Adults (1999). In the past, the elderly were viewed as invisible fragment and insignificant part of the population. However, experience is showing that the elderly are more active and visible in daily activities, politics, academics, non governmental organization and home management (Khayesi 2001).

Despite this active participation in the dévelopmental process of our nation, very little attention is given to their health and socioeconomic situation. Existing studies from developed and developing countries have shown specific situation of their nutritional vulnerability (Solomon 2000). The occurrence of malnutrition among the elderly population was established by some workers. This malnourished condition has been notices to threaten the quality of life of the elderly. For instance, osteoporosis (a condition in which there is softness of bones due to loss of calcium in the body) was associated with poor quality of life (Riggs and Melton, 1995). Furthermore, the physiological, psychological, economic and social change of the elderly, as factors conditioning dietary intake and nutritional status have been catalogues by many authors.

The nutritional status of the elderly is a key to independent life. They have access to adequate food, water, shelter, clothing and health care. This health care should involve socioeconomic conditions such as income, employment, education and food accessibility. Adequate and appropriate nutrition particularly protein, minerals and vitamins is essential to the well being of the elderly (WHO, 1999). Poor nutrition exacerbated by poverty, isolation and poor eating habit have been identified as a major problem among the elderly (Solomon 2000a). Hence, there is need to pursue health promotion or promotion of health among the elderly, prevention of diseases and maintain functional capacities among the elderly in Nigerian communities.

Surveys of elderly people showed that nutrition problems exist among the elderly (Paker, 1991). For instance in the United States of America survey of the elderly shows that 20% have not enough money to buy food they need, 30% eat less three times per day, 20% had lost weight, 30% had no one to help them in bed when sick, 25% were over weight, 30% live alone, possibly increasing the tendency to skip meal and not cook (Rolls, 1992). Nutritional workers have observed in their studies that four significant changes have taken place since youth that affect nutritional needs of the elderly. First,

body composition and the physiological functioning of many tissues change significantly in the elderly (Ritz, 2000).

Second, chronic diseases and disability are more common for instance coronary heart disease, cancer, diabetes and hypertension all of which were found to necessitate dietary change that may be difficult for some elderly people to follow. (Harris and Modan, 1994). Third, intake of prescription medications is also high for some people and these may interfere with the absorption and utilization of some nutrients (Russell 1992). Fourth, elderly people eat less, so they are less able to choose wide variety of foods that constitute a nutritious diet (Johnson and Kligman, 1992).

Nutrition scientists have also identified nutrition related changes in body functions. Ritz (2000) reported that elderly persons are likely to loose teeth for a variety of reasons especially due to changes in gastrointestinal system. Fifty percent of people aged 65 and above and 75% of those of aged 75 years and over lost most of their teeth (Timiras, 1994). Timiras also established that gastrointestinal motility could be affected by ageing. However, orocesal transit time is not increased. Despite the vast number of studies conducted on functionality of the gastrointestinal tract, there is no consensus about whether healthy old persons have a reduced capacity for macro nutrient digestion. Among macronutrients, an age-related decline in the capacity to digest fat is most commonly observed (Harper, 1998).

Other age-related changes of nutritional importance are the immune system. Impaired immune responses may be critical for the elderly. The immune system protects against micro-organisms including viruses, bacteria, fungi and occasionally parasites and against allergens, toxins and malignant cells (Solomon 2000). Nutritionists and immunologists have learned much about the immune system from the work of under-nourished children in developing countries and this is now being applied to studies on the elderly. There are many similarities and differences between the young and the old. Both age groups have less than optimum immune responses, both are at high risk of infection and adequate diet are critical for both (Ritz, 2000).

Protein energy malnutrition and deficiencies of various nutrients impair several immune responses. When elderly people take supplements of vitamins and trace elements in amount similar to recommend dietary allowances values, immunity improves and the

risk of infection decreases (Ritz, 2000). A person with limited physical capacity and strength loses mobility and independence and is more likely to fall. The consequences of decrease in lean tissue include decrease strength, physical activity and altered energy metabolism and impaired resistance to infection (Roubenoff and Rall, 1993). This finding was supported by Ferro-Luzzi *et al* (2000) that fat-free tissue mass decrease with age. This reduction is primarily associated with loss of skeletal muscle mass, although changes in other organs and tissue systems may also contribute. Loss of muscle mass contributes to reduced muscle strength exercise capacity and physical activity.

These changes were also viewed to contribute to reduce functional capacity and fractures from falls. They also observed that part of the changes in skeletal muscle mass may not be an immutable consequence of the ageing process but may occur secondary to lifestyle changes. In a situation of decrease lean body mass, few calories are required in the diet to meet energy needs, but nutrient requirements are still high. This means that the elderly must choose food with high nutrient density to meet those requirements.

2.8 POVERTY AND WELLBEING AMONG THE ELDERLY

Kalasa (2005), supported this assertion by stating that older people are consistently among the poorest in all societies, and material security is therefore one of the greatest preoccupations of old age. Many experience the same lack of physical necessities, assets and income felt by other poor people, but without the resources which younger and more active adults can use to compensate. The prevalence of poverty among older people is also linked to educational levels, including differing levels of literacy. Lack of material means is not the only problem of poverty. Another consequence is the inability to participate effectively in economic, social and political life. Older people living in poverty find themselves socially excluded and isolated from decision-making processes. This affects not only their income and wealth but also contributes to poor housing, ill health and personal insecurity. It is often argued that the informal networks of family and community in many developing countries reduce the social exclusion of older people. But this has always been contingent on factors such as the individual's gender and material means, rather than their age.

Furthermore, rapid social and economic change has often undermined the capacity of these informal networks to provide support. In many societies older people had leadership roles such as conflict resolution and cultural, religious and health education. While these roles still exist, they have been eroded by the changing structure of the family, migration and the emergence of a dominant culture, which gives higher status to literacy and formal education and has moved away from communalist forms of governance. Efforts to understand poverty have dominated much of the debate on development over recent years, but the poverty experienced by the majority of older people in developing countries has been largely ignored. In many development initiatives, such as literacy programmes or credit schemes, programme managers appear to believe that older people are unable to participate and have no productive role, or are merely passive recipients of support (Kalasa, 2005).

Heslop (1999) opined that participatory poverty research of the last decade has provided a broader understanding of dimensions of poverty that go beyond the lack of physical necessities, income and material assets. Aspects of vulnerability such as physical weakness, isolation, powerlessness and low self esteem are all factors that are often profoundly interconnected with age. In many communities age is a factor in local definitions of poverty. Older people, especially older women, are amongst the poorest as described by poor people themselves. In Ghana for example, the combination for women of age, widowhood and lack of adult children was frequently associated with chronic vulnerability. The majority of older people live in labour intensive livelihood environments. Older people are amongst the poorest because of their diminished capacity for labour that could militate against the lack of assets and income experienced by all poor people. In such communities, the significance of this may even be reflected through indigenous definitions of old age. A study of local definitions in six communities in Ghana, showed that diminishing ability to work was consistently identified as the key criterion in defining old age by both older women and men. Furthermore this criterion was used to distinguish between categories of old age; the 'new' old being identified by reduced capacity and the oldest old by complete lack of capacity to work (Norton, Aryeety, Korboe and Dogbe, 1995)

Lack of assets, isolation and physical weakness are elements of the multidimensional disadvantages to which older people are vulnerable. These are closely related to processes and institutional arrangements that exclude older people from full participation in the economic, social and political life of their communities. It is this social exclusion, the effective distancing of older people from the mainstream of their communities, which most profoundly disadvantages older people. In the public domain, even where rights exist, for example over property or access to free health care, older people frequently remain deprived through lack of information, and structures through which to pursue these claims. Public and private service delivery structures commonly militate against the potential of older people to participate as valued and active members of their societies. Older people face barriers accessing the most basic health and sanitation facilities, and are frequently denied access to bank loans and credit schemes as well as appropriate education and information. Practice in age care has tended to focus on specific aspects of exclusion, resulting in micro projects for older people rather than broader strategies for inclusion at all levels (Heslop, 1996).

Older people might be poorer just because they are less educated than the younger generations. A positive relationship between relative old age poverty and the gap in years of education between the elderly and the adult population was found by Gasparini *et al* (2007). The correlation coefficient however is small and barely significant (0.27), although Ogbu (2006) noted education to be a good measure of human development. The correlation of levels of education with levels of poverty serves as a good measure for manifestations of poverty across the quintiles. Findings in the Nigerian Poverty Survey 2001-2005 showed increasing trend of ever attending school with increasing level of quintile. About 70.0 per cent of the surveyed households had ever attended school. The ability to read and write in English language could determine the voicelessness and powerlessness of the population. The results showed that about half (52.1 per cent) of the households could read and write in English language. The quintile results showed an increasing figure with increasing levels of quintile. The poorest quintile had 40.1 per cent compared with 66.1 per cent of the least quintile. On the highest level of education attended, about half (48.0 per cent) of the households in the first quintile had no education compared with about 25.0 per cent of the households in the fifth quintile.

Household size could also be linked to the degree of income poverty, in countries where older people live in households substantially smaller than younger people, relative old age poverty is lower. In a recent study Kakwani and Subbarao (2005) found that while poverty is higher among households with older persons (particularly in rural areas) in Malawi, Uganda and Zambia, although this is not the case in Madagascar, Mozambique and Nigeria, where children were assessed to be in worse situation. Based on these pieces of evidence, Barrientos *et al* (2003) concluded that poverty in later life broadly reflects aggregate poverty. This conclusion seems correct on average, but does not apply to many countries. The housing conditions of households can also serve as proxy for welfare measurement.

In Nigeria, Ogbu (2006:23) reported that about two-thirds (66.0 per cent) of households lived in single rooms while about one-quarter (24.1 per cent) of the households lived in whole buildings. Seventy per cent of the households used firewood as the main source of fuel for cooking, more than a quarter (26.6 per cent) used kerosene, while only 1.1 per cent used gas. The use of mud for wall construction was highest (58.5 per cent) for the poorest households, while the use of cement or concrete was highest (66.0 per cent) for the least poor households. The overall access to safe water in the households was 60.0 per cent. The usage of unprotected well or rainwater was highest (23.0 per cent) in the poorest quintile while the usage of pipe-borne water was highest (28.0 per cent) in the least poor quintile, the fifth quintile. More than four-fifths (86.5 per cent) of the households participated in agriculture in the rural areas compared with only 14.0 per cent in the urban areas.

Gender wise, more males participated in agriculture. Twenty-eight per cent and 15.3 per cent of males and females respectively participated in agriculture. The poor participated more in agriculture than non-agriculture. Twenty-five per cent of the core poor households were in agriculture, while 20.0 per cent were in non-agricultural activities. A similar pattern was revealed among the moderately poor households. The non-poor households participated less in agriculture (about 37.0 per cent), with 46.1 per cent in non-agriculture. More than four-fifth (81.0 per cent) of the livestock were owned by rural households, while 91.1 per cent of the ownership was the male-headed households. This is an indication of feminisation of poverty (Ogbu, 2006).

One of the main assets of poor people is their capacity to carry out unskilled work both in market activities and in home production. Compared to the non-poor, the work performed by the poor involves, in general, a greater amount of physical strength. As people age, their ability to perform this kind of tasks diminish, affecting their capacity to keep a job or to get another one, exacerbating poverty. Gasparini (2007) suggest that the elderly are less likely to be in the workforce. This could be due to legal requirements to stop working once retired but then Nigerian situation is quite different in that they still work in informal settings.

To further analyze this issue they estimate binary choice models for the labour force participation of older people. These models are aimed at estimating the likelihood of the elderly of being employed or actively seeking for a job. They included independent variables two dummies identifying old people receiving different kinds of non-labour income (pensions payments), a set of educational dummy variables ("at most 8 years of formal education" is the omitted category), age, marital status, a gender dummy, household size, the number of household members with positive income (without including the analyzed individual) and a set of regional dummies. Consistently with the non-conditional analysis, they found that receiving pension payments significantly reduces the likelihood of being in the workforce. However, in contemporary times, pensions are becoming grossly inadequate to meet both the cost of living and the standard of living.

In general, other non-formal incomes also decrease this likelihood (except in some countries), but it is quantitatively less important, presumably because pensions represent most of non-labour income in many countries. Besides, in most cases the number of household members receiving income significantly decreases the likelihood of being in the workforce. This is consistent with the previous result. Other relatives working or receiving non-labour income provide a safety net (in some way similar to pension payments), which could make work for surviving not necessary. On the other hand, it is interesting to notice that among the elderly, in most cases, those who live in rural areas or are skilled (more than 13 years of formal education) are more prone to be in the labour force.

Reducing poverty in developing countries is a major challenge facing development stakeholders today and therefore a central theme in development (FOS, 1999a). This is because poverty has been increasing at the same rate of 2 percent as population growth in developing countries. In Nigeria, a Poverty Assessment (PA) study revealed that 87 percent in 1985 and 67 percent in 1992 of the core poor were in agriculture and that reside in the rural areas (FOS, 1999b).

Poverty and disease are inextricably linked. The higher the level of deprivation, the more the risk of experiencing undesirable chronic life conditions and deprivations. Disease often further impoverishes the poor elderly. Illness prevents people from working, or affects their productivity and lowering their income. Also conditions of poverty are associated with an absence of income security, inadequate family or social support and poor health combined with inadequate health care (Heslop and Gorman, 2000). Similarly, Udegbe (1991) notes that financial changes (poverty), bereavement and illness are life-cycle changes associated with old age, which impact on the status and well being of the elderly women.

In the same vein, two most significant events associated with old age are menopause (for women) and retirement (Olutayo, 1996). The former occurs at the stoppage of sex hormones production and this is physiologically determined while the latter is socially determined, at a point in time when one is statutorily disallowed from work as a result of old age. The retirement age is generally 60 years in Nigerian Civil Service. After retirement, the retiree is entitled only to pension and gratuity. The chances are that years after retirement will mark declining physical health and economic hardship (Olutayo, 1996).

The elderly are people who are more likely to be poor and remain poor than any other age groups because of limited income in their old age and absence of social security system. The elderly are living longer, medical costs are rising and the prospects of the elderly needing long term medical care are threatening their financial security. Many elderly people live alone and those living alone have an increased risk of being poor (O'Hare, 1996). But the upkeep of their homes, cooking meals, and caring for their health becomes an increasing chore and concern for the aged persons.

Moreover, in the face of depressed economy, high rising inflation, unemployment among others, there is a positive correlation between poverty and stress especially at old age. This is further by the socio-economic stressful conditions of the family members, that is working children and relations and friends that should serve culturally as stress depressors. The studies of Ekpenyong, Oyeneye and Peil (1987) and Eboyehi (2008) affirm that relative poverty and debilitating conditions of the elderly in Nigeria, for instance, the absolute and relative material deprivations and psychological needs of the older persons are hardly met. Though modernization should better the lot of the general populace, it is far from the case with the elderly. In respect to social integration, public health care and support, the elderly are clearly worse off today than in the past. The national economic conditions of growing inflation and reducing GNP cannot make individual family members to have adequate resources for the care of the aged population except the government do something practical (Zimmer and Dayton, 2003; Ogbu, 2006).

Chronic poverty can have a strong negative impact on the relationship between older people's ability to contribute and their ability to access support. Older persons without anything or little to give to children because of poverty in most cases miss out on such support during old age. Chances are that the children will not have anything to support both their own children and their ageing parents. This, however, arises from the fact that parents have nothing and thus children have nothing to inherit except poverty, and are not able to support the parents financially or materially even if they wish to (Kimberly, 2003). In most countries of the developing world, health services are perceived by older persons to be particularly difficult to access due to many factors including poor attitudes of health staff towards poor aged people, shortage of supplies, lack of information, lack of funds and poor implementation structures (Heslop and Gorman, 2000).

Poverty with its deleterious effects on health, education, self-esteem, quality of life and lifestyle, is one of the major concerns of older people (Okie 1991). Health for the elderly may be conceptualised as the ability to live and function effectively in society and to exercise maximum self-reliance and autonomy; it is not necessarily the total absence of disease (Harper 1988). In the same vein, to Rowe (1991), the health of older people has been approached from two different perspectives. The biomedical gerontological and

geriatrics model, commonly held by physicians and other medical personnel, defines health in terms of the mechanisms and treatment of age-related diseases and the presence or absence of disease. The functional model, on the other hand, defines health in terms of older people's level of functioning. Elderly Africans, like elderly Black Americans, tend to perceive their health according to their ability to perform activities of daily living and not according to laboratory or x-ray findings.

According to Ramashala (2000), the observation that poverty and deprivation are concentrated on a substantial proportion of older people has been a recurring theme of research on ageing in all industrialized societies. In the United Kingdom, for example, older people have been reported to be the largest group in the population living in poverty ever since data were first collected systematically. Subsequent research in other parts of the world has confirmed that repeatedly, the deep-seated nature and extent of poverty is three times greater for older adults than it is for other age groups. Not only does poverty affect a substantial proportion of older people but also when it does, it is likely to be an enduring experience. The high incidence of poverty and low income among older people is reflected in other measures as well. Moreover, the problem of poverty in old age is not peculiar to industrialized societies; it is endemic among both Western and Eastern countries as well as Third world countries.

Writing on the issue of poverty among the elderly Bose (1994) and Tout (1989) concluded that there is need for a high level organization, which would protect and promote the need of the elderly. The emerging issues they identified include the decline in the joint family, changing value which emphasizes the needs of the immediate family, fewer children as care providers to the elderly, greater female employment demands, migration of the young, limited housing in the urban areas, complex living conditions due to modernization and the economic dependence of the elderly.

2.9 LIFE-CHANGING EVENTS AND WELLBEING OF THE ELDERLY

There are three life-changing events which affect people entering old age in relation to their wellbeing, namely (1) Withdrawal from the labour market, (2) Changing course of family life with its household living arrangements, and (3) the gradual but irreversible decline in health status.

2.9.1 LABOUR MARKET AND POVERTY IN OLD AGE

According to Molnar (2005), one of the decisive life-changing events affecting wellbeing of the elderly is the discontinuation of economic activity, and its consequence, that is, reduction in income. At the turn of 2001/2002, the majority of the male population aged 60–75 had discontinued their economic activity before they turned 60, and nearly 80 per cent of women had done so before they reached 55 years of age. With very few exceptions, by the time people reach 60 years of age they will experience the unhappy consequences of discontinuing their economic activity, and seeing their income fall. Obviously, this could be a proof not only of the higher difficulty of finding jobs for the elderly, but also of retirement choices. Moreover, a large employment share of the elderly is not necessarily a social encouraging development but, this could be the consequence of the lack of a strong social security system. In developing countries such as Argentina, Chile, and Uruguay, which have relatively developed social security systems, the employment rate of the elderly reaches the lowest values obtainable. In these countries, the average share of older people employed is around 25% (the lowest being Uruguay with 17%). In contrast, the highest rates correspond in general to poorer countries without extended pension systems (Thorbecke, 2005).

The dynamics of change in the years between 60 and 75 differs markedly for the male and female population. Among women, the number of persons living in a one-person household doubles, and the number living with a spouse halves. However, for men the situation is different. As they approach 75 years of age, the proportion of them living in one-person households certainly increases, but the number living in two-person households, as part of a couple, increases as well. The explanation for this is that the spouses and the children, of such men are younger, and hence the children are, at this time, just starting to build their own lives, separate from the parental family, whereas the children of women in the same cohort have already gone through this development. In other words, for men family life runs its course in a slower, more protracted manner than for women. However, it also begins later. Male-headed households were more likely to be in poverty (Troisi, 2004).

Social security has reduced the poverty rate for elderly women in United States, their poverty rate is still higher than men - 11.8 percent compared with 6.9 percent. The

rate is highest among elderly women who are divorced - 20.4 percent (Anzick and Weaver, 2001). Much of the difference between the economic status of men and women in retirement can be explained by examining how the life experiences of women particularly earnings patterns and life expectancy differs from those of men. Women have lower lifetime earnings than men. In 1998, the median earnings of full-time, full-year working women was $25,862, compared with $35,345 for men. Between 1960 and 1980, women earned about 60 percent of what men earned. However, from 1981 through 1998, women's earnings as a percentage of men's gradually rose to 73 percent. Although the difference between women's and men's earnings is expected to continue narrowing, it is not expected to disappear.

Women spend fewer years in the work force than men. Women are more likely to take time out of the workforce to care for children or elderly relatives. Of retired-worker beneficiaries aged 62 in 1998; the median number of years of covered employment was 38 for men and 29 for women. That gap is projected to narrow in the future, but women are expected to continue spending fewer years in the workforce than men. Women live longer than men. At age 65 in 2000, women can expect to live 19.1 additional years, and men can expect to live 15.8 years or 3 years less. At age 65 in 2030, women are expected to live 20.4 years, and men are expected to live 17.5 years or still 3 years less. Because women's life expectancy is greater than men's, they are more likely to outlive their resources and slip into poverty. Women are less likely to receive pension income and have lower financial net worth. Only 30 percent of women aged 65 or older were receiving pension income in 1994 (as a retired worker or survivor), compared with 48 percent of men. That situation will improve in the future because about 49 percent of women and 50 percent of men who currently are full-time, full-year workers are covered by a pension (Asiyanbola, 2005).

However, women's pension income will still be lower than men's because their earnings and years in the workforce will still be lower. In 1993, female household members aged 65 or older had a median financial net worth of $9,560 (excluding equity in their home). In contrast, the median financial net worth was $12,927 for aged male householders and $44,410 for aged married couples (Anzick, and Weaver, 2001).

Poverty has a relevant age dimension. Both needs and income potential change over the life cycle, modifying the probability of falling into poverty. In developed countries the combination of strong social security systems, well-developed capital markets, and small households contribute to higher living standards for the elderly, relative to the rest of the population. These conditions are not replicated in many developing countries, where pensions systems are weak and mostly favour the non-poor, the long-term formal credit market is almost inexistent, and the elderly usually live in large extended households sharing the budget with a large number of children. Identifying the extent to which older persons are affected by poverty vis-à-vis the rest of the population is essential to include the age dimension into social policy discussions (Gasparini, Alejo, Haimovich, Olivieri, and Tornarolli, 2007).

Poverty is usually viewed as lack of income - expenditure or consumption; lack of capabilities and freedoms – both intrinsic and instrumental (e.g. income, education, health, human rights, civil rights, etc.) that permit people to achieve what they want to do and want they want to experience; and a form of absolute or relative deprivation. It has further been pointed out that the state of being poor can be severe, multi-dimensional and chronic, although the three aspects also build on each other. Chronic poverty is one that lasts for an extended period of time and this could be both severe and multi-dimensional. Commonly, the chronic poor experience several forms of disadvantage at the same time and these combinations block off opportunities for escape (Hulme, Moore, and Shepherd, 2001).

According to Gasparini *et al* (2007), poverty is certainly a multidimensional issue. An individual is considered as poor if her living standard indicator is lower than a given threshold, known as the poverty line. The practical implementation of this definition requires the choice of a proxy for the individual well-being and a poverty line. Most of the economic literature suggests using household consumption adjusted for demographics as the welfare variable, and a poverty line that combines a certain threshold (largely arbitrary) in terms of consumption of calories, with the consumption habits of the population, and the domestic prices of goods and services. The elements needed to construct a poverty line are idiosyncratic to each community, a fact that leads to wide differences in the national lines across countries, and introduces serious comparability

problems. For this reason cross-country comparisons are usually made in terms of some simple international line. The most popular one is the US $1-aday line proposed in Ravallion *et al.* (1991). It is a value measured in 1985 international prices and adjusted to local currency using purchasing power parities (PPP) to take into account local prices. The US $1 standard was chosen as being representative of the national poverty lines found among low-income countries. The line has been recalculated in 1993 PPP terms at US $1.0763 a day (Chen and Ravallion, 2001). The US-$2-a-day line is also extensively used in comparisons across middle-income countries. Although the USD-$1 or $2-a-day lines have been criticized, their simplicity and the lack of reasonable and easy-to-implement alternatives have made them the standard for international poverty comparisons. For instance, the United Nations' Millennium Development Goal No.1 – eradicate extreme poverty and hunger – is stated in terms of USD-$1-a-day poverty – halving between 1990 and 2015 the proportion of people whose income is less than USD $1 a day.

2.9.2 DEMOGRAPHIC CHANGES AMONG THE ELDERLY

The second decisive life event is the change in family arrangement type. For many, the classical family-life period comes to an end between the ages of 60 and 75 with the death of their spouse. It is around this time, too, that their children often leave home. These two family events—coupled with retirement—direct people to establish a new lifestyle. The household becomes a single-member one, or else the elderly couple remain on their own. A further type of family arrangement is when the widowed parent (most often the elderly woman) is forced to give up her independence and move in with one of her children—or have the child's household move in with her—and, from then on, live on the periphery of the young family or household. Studies of household income show categorically that moving in together is largely the choice of families on a lower income (Salamin 2004).

According to Sijuwade (2007), in traditional society, family has been the most natural and conducive social organization for the care and support of the old aged person. The care and support to old aged person was provided by the family members, especially the wife, sons, daughters, sons-in-law, and daughters-in-law. This care giving was backed not simply by the emotional bonds of relationship emerging out of blood relationship or

marital relationship but by the force of pervasive influence of traditional values, norms, and behaviour which were not simply practised as a matter of routine but also deified. The care of the elderly was the moral imperative which was considered not only material bliss but also spiritual salvation (Gore, 1992). However, this traditional bond between the elders and the younger members of the family is gradually becoming weak.

The effects of rapid demographic and other social and economic changes have called into question the continuing capacity of the family to provide effective care for older people. The available evidence suggests that for the vast majority of older people, family support, whether in the context of co-residence with adult children or not, still provides the main source of care in old age. In Cambodia for example, research in five of the poorest villages found that support from children was the most widely used survival strategy of older people. Family support systems are under pressure but have not broken down. The changing nature of family support arrangements in increasingly difficult circumstances is testimony to its resilience. This is demonstrated in poorer communities where alternative services and choices are absent and at the same time the capacity of the family to care is most at risk. Family support can be seen as a necessary but not sufficient guarantee of old age security. Poverty of the community and in the family remains the greatest threat to the security of older people. Even co-residency is no guarantee of effective care for older people, many of them stay with their families in a state of material and emotional neglect. For families trapped in endemic poverty, the capacity of younger generations to assist their older relatives is severely impaired (Salamin 2004).

As the elderly constitute an increasing proportion of Nigeria's population, it is pertinent to examine their needs and concerns, which have direct impact on their socioeconomic wellbeing and quality of life. It is often assumed that the family will automatically take on the responsibility of caring for the elderly, yet little is known about the contemporary condition of the elderly within this safety net in practice. Currently, little is known empirically about the link between family care situation, daily activities, housing and the physical well being of the elderly - awareness, and knowledge of which could inform elderly sensitive policies.

Kumar and Anad (2006) noted similarly that industrialisation, wherein production of goods with the use of hand-tools is replaced by power-driven machines, gives

importance to individuals rather than kinship groups. Homogeneity of outlook among the family members decreases, modernisation, technological change, mobility and the explosion in the lateral transmission of knowledge have introduced changes in lifestyle and values, younger people are increasingly formulating their own visions of society; challenging the established order and moribund traditions – they are therefore likely to come into conflict with the elderly. The gradual migration of young people towards large industrial complexes; the enforced crowding together of large communities in confined spaces has, ironically, signalled the erosion of the neighbourhood systems and this acts as a severe constraints in common residence of the elderly with their sons, the migration of younger population to cities and towns, which increases the vulnerability of the old who stay behind, specially for those who do not have a independent livelihood or assets such as land, livestock or household industry but are primarily dependent on their labour, the increasing numbers of women seeking employment in offices and factories – this impinges on their time for taking care of the elderly, many of whom may need constant care. Further, decline in the status of elderly women is due to less importance in socio-religious ceremonies; and the enormous expansion of education, which raises the cost of bringing up children, and adds to the pressure on families to alter expenditure priorities in favour of the younger generation, thereby affecting the intra-family distribution of income. As a result of these forces, the joint family system has come under severe strain, thereby increasing the vulnerability of the elderly. Along with these trends, there has been a simultaneous change in the demographic profile of developing countries (Heslop and Gorman, 2000).

From the time immemorial, the wellbeing of the elderly was tied to care within the extended family system. The elderly are cared for by their children, son's wife and the extended family members, particularly the women. There is the practice of marrying young girls by the elderly men, and at times his children may marry the young girl for him to take care of the elderly man's need. Some parents do send their children home to live with the grandparents so that they can run errands for them while the grandparent teaches them cultural and moral values. Within the traditional system the social obligations of the aged were multi-dimensional in the sense that they encompassed religion, 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 put into doubt the continued viability of such traditional arrangements for the elderly. Such changes like increased emphasis on smaller family units, migration to urban areas, more working wives, new life styles and changing values, all have effects on the traditional forms of care of the elderly. Financial difficulties have made it imperative for many women to now work for pay outside the home and also the issues of education for the young have reduced the caring role of the grandchildren (Asiyanbola, 2005).

Heslop (1996) stated that the effect of demographic changes on family structures and relationships is one of the main areas of concern in the literature on ageing. Throughout the world the family is regarded as a basic component of the social structure and a key role assigned to the family is that of providing care to family members at every stage of life. Care in old age is perceived as a special responsibility, particularly in the absence of public support structures. In most societies, where daily care or nursing is needed by older relatives, this responsibility is assigned to female family members. Changes in life expectancy, economic opportunity, social and geographical mobility are impacting on living arrangements and family relationships.

The opportunity to have fewer children provided by effective contraception means that investing in children's health care and education is increasingly seen as the preferred means of ensuring security in old age. The trend to smaller or attenuated families implies an increasing number of older family members and fewer available family carers. Other factors such as the increasing numbers of women engaging in formal work, migration and urbanisation do not necessarily lead to isolation of older people but may reduce the availability of preferred family carers. Increasing numbers of older people are living alone, as a result of increasing numbers of people who do not marry or do not have children. There is a significant gender issue, since women's greater longevity in almost all countries in the South and their earlier age at marriage, mean that widowhood is almost a fact of life for women over 75 in these countries (HelpAge International, 2002).

The focus on the capacity of family support networks to care for older people often ignores the reciprocal nature of this intergenerational support. Older people are by no means simply passive receivers of care, but more often are active contributors to

household economies. In subsistent economies older people contribute their labour, providing for their own survival until they are no longer physically capable (Heslop, 1996). There are factors such as urbanisation migration, education and changing labour markets have contributed to changes in residency patterns and household economies. The ways in which this affects the ability of the family to provide support for older people need careful assessment. While urbanisation may contribute to isolation of older people remaining in rural areas, there may be important economic compensations through remittances. In communities where poverty is linked to deterioration in the quality and availability of land, economic migration of children can provide opportunities for supporting older parents that they would not otherwise have.

Remittances from children who find employment in urban areas or other countries are regarded as important elements of support. However, the reverse might be the case. Increasing stress of migration to urban areas may have a negative effect on interdependency relationships. In most developing countries, centrally developed systems for income security in old age are extremely limited. In practice, eligibility is restricted to a small minority of workers previously employed in the formal sector in urban areas, such as government staff and employees of large scale public or private enterprises. The livelihoods of most elderly people are based on multiple activities and sources of income and security outside the formal economy (Heslop, 1996).

Old age security can be substantially enhanced by wide ranging measures aimed at strengthening the capacities of older people to contribute to and to be included in the process of development. Governments have a role in supporting indigenous institutions and forms of social security as well as developing new forms. Research suggests that traditional reciprocity networks and risk reducing mechanisms, weakened by new markets and state interventions, may not be relied upon as the only form of security but that opportunities exist for scaling up of social capital. Religious societies, traditional councils, savings groups and burial societies are among the institutions identified by older people as part of their support networks in many societies. It has been suggested that the fostering of relations between the state and these informal networks can create an environment of civic engagement, facilitate collective action and also strengthen state institutions. The gap between public and traditional or community based institutions is

not as wide as commonly supposed as informal networks span the public and private domains. In Ghana, for example, local government operates at village level through bodies called unit committees. Members of these committees and members of traditional councils live in the same community, and work together with the shared responsibility for community development. While the unit committees represent community concerns at district level, they recognise that decisions must be made in agreement with traditional councils. The development of partnerships between public and private institutions implies the inclusion of the business sector, especially in the development of more accessible and flexible savings or pension schemes (Dennis, 1998).

The World Bank estimates that over 70% of the world's older population rely on informal systems of security and this percentage is certainly higher among older populations in the South. Despite this awareness, much of the debate regarding income security for older people builds on the assumptions that old age is synonymous with dependency and that the economic welfare of the older population is largely determined by the performance of the economy as a whole. This perspective is evident in the World Bank report of its cross national study of old age security arrangements which establishes policy options to militate against the expected economic dependency effects and increased social welfare costs of ageing populations. This situation is expected to be particularly acute in poorer countries which are experiencing population ageing most rapidly and which have limited capacity to support them. The report proposes a framework for identifying the policy mix most appropriate to a given country's needs based on a three pillar system combining public mandatory systems, private mandatory systems and personal savings schemes (Apt, Koomson, Williams and Grieco, 1995).

Apt, Koomson, Williams and Grieco (1995) noted that whilst the framework is useful for governments reviewing or developing formal pension and social security programmes, taken as a single reform agenda, it is problematic. Firstly, the prospect of poorer informal workers contributing to private pensions or savings schemes has not been adequately assessed. Secondly, in many less developed economies the preconditions to secure long term private savings, such as stable markets and sound regulatory structures, do not exist. The World Bank report therefore recommends that such reforms be seen as complimentary to programmes designed to protect the informal systems of old age

security which are the mainstay in most developing countries. Moreover, the evidence that population ratios necessarily translate into economic dependency ratios in all societies needs further analysis. It is assumed that transfers of wealth flow upwards from younger to older generations. Household expenditure and consumption data generally assume that household members consume equally. There has been little age aggregation of consumption of public services such as health and education in poor countries. One of the first empirical studies carried out in a high fertility country, Côte d'Ivoire, found that intergenerational wealth flows are downwards in both public and private domains. The study used data on labour income and household enterprise labour as well as public sector resource flows against age profile information to analyse population wealth. In rural areas it was found that people move from being net consumers to producers earlier than in urban areas, due in part to longer time spent in education in urban areas. But in both rural and urban economies the average age of labour earnings was higher (by 7 years) than the average age of consumption (Apt, 1994).

In the public sector, distribution of services and transfers received were dominated by the younger generation, primarily through schooling. Comparing government transfers and receipts against age profiles, public sector transfers are provided by individuals who are 18 years older than recipients of government services (Stecklov, 1997). On the basis of this evidence, neither the public nor market based economy should be threatened by increasing proportions of older people. The challenge for most countries is more likely to be concerned with redistribution of resources in pace with changing age profiles. Where national provision for old age security exists, as in South Africa, the impact of this on older people and the wider community can inform development of policy elsewhere. The government currently spends three quarters of the welfare bill on old age pensions. Observers agree that this is well targeted to reach poorer households; that it is the major source of income for many extended families and that it has a development impact. People are fed and sent to school out of this pension money, it enables investments in farming activities, and in general it is crucial for the very survival of these communities. All this is in the context of very high unemployment especially in black and coloured communities (Stecklov, 1997).

A study of households in settlements in Cape Town, where 65% of the working population are economically inactive, found that in the households the pension was the sole source of income. However, because these households attract economically weaker dependants they are described as disadvantaged in comparison to younger households. Due to high unemployment and the absence of other forms of social security, the pension in South Africa has been described as an imperative for the very survival of many urban poor. The effect of this on older people needs further research. One study with older people in a Durban township, found that older people were highly vulnerable to physical and psychological abuse because of the pressure on this income. Other main issues were access to health care, housing and transport services. In responding to these issues older people spoke consistently about their perceived lack of education and their feelings of inadequacy because of this. This raises questions about the relationship between pensions and wellbeing for older people, particularly in relation to issues of self esteem and adequate healthcare. It cannot be assumed that guaranteed income is enough to provide social security in old age (Zaidi, 2006).

One of the reasons why the informal sector has been overlooked in national planning stems from the view that age itself is a barrier to national productivity and growth. The reality is that livelihood strategies in old age remain complex and diverse. They include capability to engage in productive activities such as farming, trading, and engaging in small scale enterprises. They also include assets such as good health, knowledge, skills, and access to family and community support networks. In maintaining their livelihoods older people contribute to the wellbeing and livelihood of the household and family. Factors that reduce these assets and limit the capacity of older people to provide for themselves include diminished physical strength, poor health, low status, landlessness, absence of or limited family or community support, lack of capital, and lack of education or training opportunities (Heslop, 1996).

2.9.3 DETERIORATING HEALTH OF THE ELDERLY

The third important change in old age is the decline in health. According to statistics on health, elderly people require more medical treatment than the young. For instance, in 2001 one third of those treated in hospital were over the age of 60, as were 20 per cent of those treated in specialized outpatient clinics (Molnar, 2005). Subjective

assessment of wellbeing helps provide more information. Aside from the process of aging, the number of those struggling with minor or more serious health problems is increasing dynamically. As retirement age approaches, there are more people who find daily routine tasks a problem, than who do not. There are important differences between men's and women's perception of their own health. Men, despite their shorter life expectancy, consider themselves to be in better health than do women. It seems that those men who 'survive' are healthier. At the same time, women visit their doctor more often with health problems, and therefore their illness awareness is also stronger than men's (Molnar, 2005).

Wellbeing is an important dimension of poverty. Poor people usually suffer from precarious sanitary conditions. This not only directly affects welfare but also interacts with many related aspects of health. For example, bad health reduces productivity and diminishes the ability to manage knowledge. In order to analyze the health dimension, a sample of surveys (in most cases Living Standard Measurement Surveys) was used which include questions on several health issues. Health issues are particularly interesting when studying old people's well-being. Aging is strongly linked to health deterioration. Other things being the same, the health of older people is expected to be worse than that of the rest of the population. Naturally, this phenomenon is also reflected in the likelihood of being ill (Haimovich, and Winkler, 2005).

In countries where demographic changes are occurring most rapidly, technical innovations have had more impact on health gains than rising standards of living, better nutrition, sanitation and housing that accompanied these demographic changes. Interventions such as mass vaccination programmes have been made in the context of continuing poverty rather than in the context of gradual and wide ranging social and economic improvements (Ushasnee, 2004). The implication is that for many people in poorer countries old age may well be accompanied by chronic ill health, as a result of lives lived in poverty with minimum access to adequate healthcare facilities. Comparisons of health trends indicate that patterns of morbidity observed in the North are now emerging in the South and featuring an increasing incidence of degenerative diseases. Although morbidity remains skewed towards infectious diseases, it is increasingly moving towards degenerative diseases in most developing countries. It is

also observed that industrial and environmentally caused diseases pose an increasing risk in these countries. Gender differences impacting on health affect not only health status but provision and access to healthcare facilities. Women outlive men but not necessarily with longer periods of good health. Poor women's lives are often characterised by time consuming and physically demanding work, inadequate nutrition, repeated childbirth since puberty and little access to primary healthcare. Older women are more likely than men to spend more of their older years in a disabled state. Although many public health programmes have budgetary and delivery mechanisms for targeting younger women and children, there is scant recognition of the specific health needs of older people and even less awareness of the different health profiles of older men and women.

The impact of HIV/AIDS in a number of societies has resulted in increasing numbers of older female headed households supporting orphaned children. The responsibility of care falls on older women, whose capacity for productive labour may be significantly reduced, thereby increasing trends towards the feminisation of poverty. For older people, personal health consistently ranks alongside material security as a priority concern. For the majority of poor people whose livelihoods are closely connected with their ability to work, illness can mean the loss of means of self support. This is a very real threat for older people without assets and little family support, who are at the same time those who are least likely to be able to access adequate healthcare services. Access to public healthcare is problematic for older people. Whilst the majority of older people live in rural areas, healthcare facilities and personnel tend to be concentrated in urban areas. Even where facilities exist such as health posts and clinics that are relatively accessible for some members of the community, lack of transport or cost of transport and high fees are prohibiting factors for older people, who are less able to make the journeys required on foot. In some communities this affects women in particular. A study of health and older people in rural Somalia, where only 50% of the population have access to public health facilities, found that social mobility patterns meant that it was mainly men between the ages of 40 and 70 who could travel beyond their villages to access these services (Gist and Velkoff, 1997).

In a survey of the poverty situation in Nigeria, Ogbu (2006) opined that the status of health is a strong indication of human development and can also serve as an indicator

for poverty and it has been revealed that about 8.0 per cent of the Nigerian population consulted healthcare providers because of low level of awareness, poor facilities and high cost. The quintile analysis showed that about a quarter (25.56 per cent) of population in the first quintile (the poorest) and more than half of the population (56.0 per cent) in the fifth quintile (least poor) consulted medical doctors. The same survey indicated reasonable consultation with traditional healers by all levels of quintiles. About 12.0 per cent of the population of the first quintile and 8.0 per cent of the population of the fifth quintile consulted traditional healers.

Evidence from a number of studies suggests that public health services are a relatively minor element of older people's overall health care strategies. Home remedies, self help, visits to herbalists, bone setters and spiritual healers, and purchase of drugs in the market play a very significant role in both urban and rural areas. Choices are affected by social, economic and cultural contexts as well as personal circumstances. As one group of older men in Northern Ghana explained "when somebody is sick you start with home medication, if you are not successful you go to the herbalist, then the peddler, clinic and finally the hospital - a last resort." Older people in a community in Northern Province in South Africa are comparatively well provided by a community health centre and nearby hospital, but use these in combination with other forms of healthcare (Ramashala, 2000). Many older people in this community believe that hospitals provide temporary treatment for diseases while healers provide permanent cure. Although traditional healers are considered to be expensive, there is no fixed amount and treatment involves several stages that are paid for separately and in the form of animals such as chickens or goats depending on what is agreed for the task.

Activities of daily living are important indicators of the health, functional status and wellbeing of older persons. Hitherto, empirical study on the elderly activities of daily living in Nigeria is few. Daily activities investigated were distributed among the four categories of domestic chores, household maintenance, service to others and social activities. Domestic chores include the following activities: cooking, household shopping, fetching water and daily involvement in domestic activities generally. Household maintenance include the following activities: cleaning the house and the surrounding, and getting rid of household waste. Service to others includes the following activities:

attending religious service, going to work-place or involvement in paid employment, and childcare. Asiyanbola (2005) found that in Nigeria, the elderly generally are more involved in service to others (50.8%), followed by domestic chores (25.2%), household maintenance (25.0%) and social activities (9.4%). In the categories of domestic chores and household maintenance more women (33.6% and 31.3% respectively) are involved than men (16.7% and 18.6% respectively). Also, in the category of service to others more women (52.8%) than men (48.8%) are involved.

2.9.1.1 THEORETICAL FRAMEWORK

Theoretical framework gives shape to ideas and ideas also are shaped or structured into theoretical frame within a specified domain to guide or show the relationships between the theoretical ideas (concepts) and the empirical materials (data / information) that are outcomes in the study. In other words, theoretical framework helps to explicate the nature of social reality. "Within sociology, a theory is a set of statements that seek to explain problems, actions or behaviour. An effective theory may have both explanatory and predictive power. That is, it can help us see the relationships among seemingly isolated phenomena as well as understand how one type of change in an environment leads to other changes" (Schafer 2005:8). It is clear that theories attempt to explain the nature, character and pattern of social reality.

The relationship between structural social contexts and individual behavioural contexts has been a persistent theme in sociological theory and conceptual framework development. Therefore to understand the relationship between the challenges of poverty and wellbeing of the elderly in the study area, these two theories were employed; namely Anthony Giddens' Struturation and Successful Self-Management of Aging Theories.

2.9.1.2 ANTHONY GIDDENS' STRUCTURATION THEORY

This study derives its theoretical basis from Anthony Giddens' Structuration theory (1984). In other words, the theoretical perspective of agency/structure integration was employed in analysing the situation of the elderly with respect to poverty and health in

Iwo. In this regard, a pertinent question to ask is; how are the elderly in Iwo living and coping with the problem of poverty and their naturally degenerating health?

Structuration theory is one of the most articulate efforts to integrate macro and micro sociological perspectives. That is, the combined analysis of agency and structure. To Giddens, the duo cannot be conceived of one from another, that is, they are two sides of the same coin. All social action involves structure and all structure involves social action. The two concepts are inextricably interwoven in human activity. With its focus on social relations, it intends to illuminates the duality and dialectical interplay of agency and structure.

Giddens used 'structuration' to describe the symbiotic relationship between human agency and social structure (1984). He talked about the 'duality of structure' to explain the mutual causal relationship between the two. For instance, English language is a structure; it comprises communication rules because the syntax cannot be changed at will by members of the society. However, the reproduction of the language depends on spoken or written words by individuals in ways that follow its existing rules.

Applying this analogy to this study at the level of structure, poverty among the elderly can be explained in terms of how the society is 'structured' by human actions. On the basis of old age, the elderly get retired given the age-limit stipulated in the civil service and this affects their financial and health status and general well being. Also the failure of the government further spreads poverty and ill-health among the elderly, especially in African nations, without old-age social security system.

At the level of agency, the intentional elements of the agents constitute the flow of everyday life. However, intentionally oriented actions also have unintended consequences and these feed back to become the unacknowledged conditions of future acts. That is to say at the instances of action of which an act initiates a sequence of acts, which together produce a consequence without the actor being aware of the sequence. To explicate this analogy in this study, the elderly persons with little or nothing to save or invest early enough are indirectly creating poverty for themselves because they will have little or nothing to reap except poverty, which will feed back to become unacknowledged conditions of their material deprivations, which will impinge on their health status by extension.

It can be deduced from the central arguments of Giddens that youths, adults and elderly are the main human agents creating and recreating social relations over space and across time beyond the primordial condition of face-to-face interaction. The elderly and their children engage in intergenerational relations. Therefore in this study, attempt to account for how the elderly in Iwo maintain social relations with their children in cities was made within the contexts of poverty and wellbeing among the elderly in Iwo.

Further, Giddens in his approach pointed out that society is not a pre-given objective reality but is created by the actions of its members. Every human action or structure involves three aspects: meanings (things known, the stock of knowledge), morals (value systems), and power (patterns of domination and division of interest). A critical analysis of Giddens theoretical postulation especially the aspect of meanings can be used to explain the global attention being directed to this question of old age strongly associated with the elderly, that it is seen as problem-related following the knowledge of its implications and challenges worldwide today. As such, old age variable as structure in Giddens thought is a function of the actions of individual agents engaging in social practices. There have been several conferences, meetings and the like at different times on how to address situation of the elderly, following its widely shared meanings; that is to live successfully in old age.

More so, structure has the dual capacity both to constrain and to enable (provide resources for) human agency. The focus for the Structuralists is that the processes by which structures are constituted through action and action is constituted structurally. The conceptual core of Structuration theory lies in the ideas of structure, system and duality of structure. Structure is made possible by the existence of rules and resources. Structures themselves do not exist in time and space; rather social phenomena have the capacity to become structured. In Giddens analogy, structure only exists in and through the activities of human agents and that structure is what gives form and shape to social life but it is not itself that forms and shapes.

Applying the above to this study, presumably structure such as old age can be constraining in that the elderly, who may not work actively anymore will find it difficult to take good care of themselves unlike before because of their failing health. Also, institutionally old age is even a key factor of disqualification to secure employment and

credit facilities for elderly persons. On the other hand, the elderly are held in high esteem in some societies and regarded as contributing positively to the progress of the society by the virtue of their wealth of knowledge, wisdom, and custodianship of social values, culture and tradition.

Another major component of this theory is that human agents continuously monitor their own thoughts and activities as well as the physical and social contexts. In their search for a sense of security, actors rationalize their world. By rationalization, Giddens means the development of routines that do not only give actors a sense of security but also enable them to deal efficiently with their social lives. Actors also have motivations to act and these motivations involve the wants and desires that prompt action. However, in Giddens' view, motivations are gradually unconscious and they play a significant role in human conduct. Using this approach as a guide in this study, effort was made to investigate the unconscious motivations in Giddens' thought, that the elderly and the non elderly have created and still creating as a result of old age to ensure a sense of security.

2.9.1.3 SUCCESSFUL SELF- MANAGEMENT OF AGING THEORY

Aging successfully seems to be important for everyone (Kahn, 2002). It is generally recognized that successful aging means staying physically healthy and maintaining social and psychological well-being over the life span. However, with increasing age, many people experience losses in different domains of functioning. These losses lead to a complex mixture of separate or interacting problems, a condition often called 'frailty'. Frailty increases the risk of adverse outcomes, such as inadequate use of health care, dependence on others, personal suffering, caregiver burden and adverse health outcomes. Knowledge of what needs to be done to delay or prevent frailty is mainly in the physical realm, for instance, the treatment of cardiovascular risk factors. In the psychosocial realm, this delaying mechanism is yet unclear. Adaptive mechanisms possibly delay frailty (Lorig and Holman, 2003). Owing to increasing number of elderly people in society, the impact of frailty on the well-being of the population is becoming increasingly substantial. This points to an important societal problem and raises the question of what can be done to counteract the negative effects of frailty on well-being.

A theory that provides substantive opportunity for success in terms of dimensions of wellbeing, that emphasizes positive and sustainable aspects of well-being, and that considers direct and adaptive resources together is the Successful Self- Management of Aging Theory (SSMA theory) (Steverink, Lindenberg and Omel, 1998). Because this theory specifies criteria for 'success'; that is substantive dimensions of well-being and both direct and adaptive resources are needed to reach and maintain well-being. It may give concrete guideline for which aspects to consider helping elderly people to age with as high level of well-being as possible in the face of frailty.

Physical and social well-being can be achieved by realizing five substantive goals or dimensions of well-being: comfort and stimulation (for physical wellbeing) and affection, behavioural confirmation and status (for social well-being) (Steverink, Lindenberg, Omel, 1998). For instance, when individuals realize comfort and stimulation, this contributes to their physical well-being, which in turn contributes to their overall well-being. These five goals are realized by using resources such as endowments or skills and their realization makes up the criterion for 'success' in successful aging. The SSMA theory specifies how people can realize and sustain well-being during aging. The theory postulates two kinds of resources necessary to realize well-being: direct resources (for instance, hobbies to realize stimulation or a close friend to realize affection) and adaptive resources, that is, self-management abilities. The latter resources are thought to be especially important for aging with high well-being because they are needed to gain and sustain direct resources. As such, the resources may be of much relevance to frail elderly people who are confronted with many losses in direct resources.

The six self-management abilities (Holman and Lorig, 1997), which are thought to be the core abilities necessary to sustain well-being during the life-span, are:

- Multi-functionality of resources to realize well-being (they enable realization of various goals simultaneously and thus create synergetic effects);
- Variety in resources to realize well-being (such that one has more than one resource to realize a specific dimension of well-being and such that one can substitute or compensate for lost resources);

- Having a positive frame of mind or perspective regarding expectations for the future (one also expects maintenance or growth of resources, instead of only further loss);
- Investment behaviour (to maintain and achieve possible growth of resources with the aim of sustaining well-being in the longer term);
- Self-efficacy beliefs (beliefs in one's competence to realize well-being);
- Taking initiatives or being proactive (with regard to realizing well-being).

In the SSMA theory, the self-management abilities are systematically directed towards the six goals of well-being, the realization of which is the criterion for successful aging. Examples are taking the initiative not just with regard to comfort but also with regard to stimulation, status, behavioural confirmation and affection. Only when the abilities are directed at each of the substantive dimensions of well-being then they contribute to successful self-management of aging. The systematic direction of the abilities to the dimensions of well-being makes it possible to derive concrete guidelines regarding how to improve successful aging (Rowe and Kahn, 1997).

The self-management abilities (SMA), are interdependent and often mutually reinforcing. For instance, having a positive frame of mind might lead to investment in resources, and investment in resources might in turn lead to having a variety of resources. For this reason, the self-management abilities contribute jointly to well-being. The six self-management abilities together constitute the overall concept of successful wellbeing (Lindenberg, 1996).

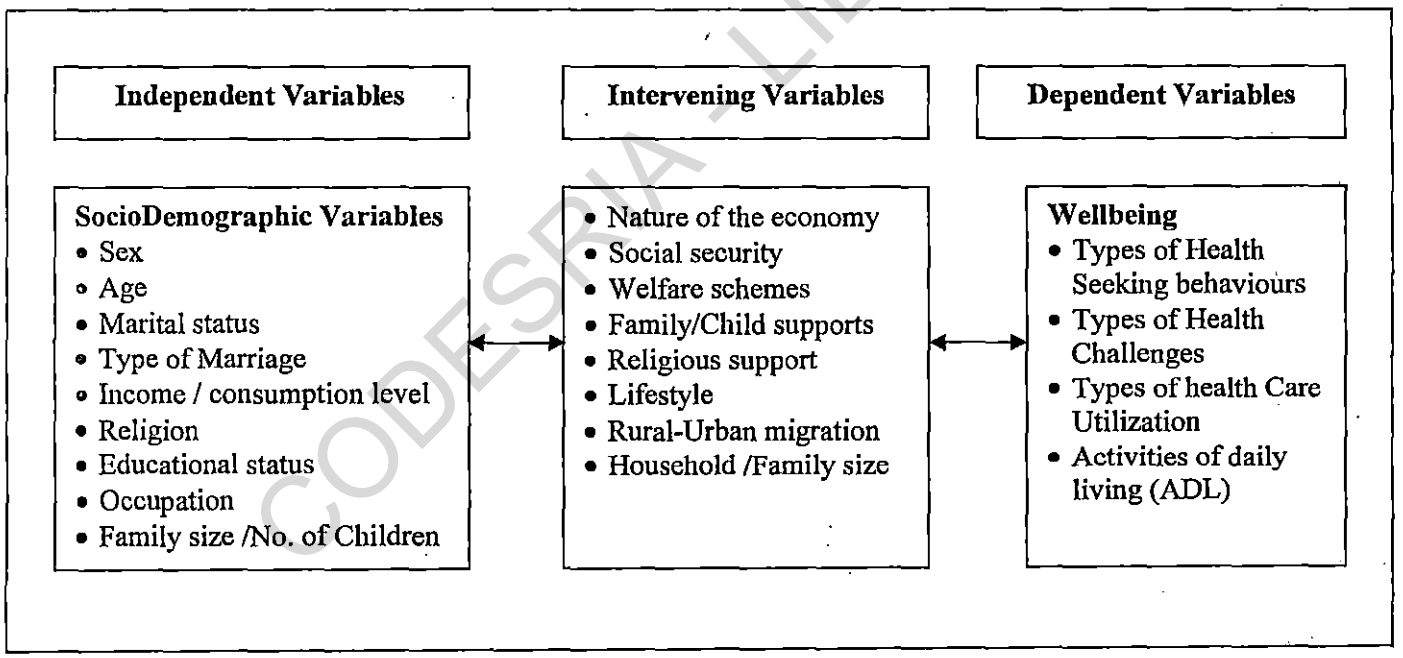
Both direct resources and self-management abilities are thought to be threatened by aging (Steverink and Lindenberg, 2003). Direct resources decrease because of losses related to aging, such as the loss of social roles, the loss of people in the network, and the loss of physical energy. Self-management abilities decrease as a consequence of the loss of direct resources. Declining physical faculties, decreasing participation in different roles, increasing experience of loss and failure, declining positive expectations regarding the future, and increasing dependence on others lead to a decline in self-management abilities. The more people age and the frailer they become, the more difficult it is for them to maintain these self-management abilities - that is, the more difficult it is for them

to be good 'self-managers' (Ormel, Lindenberg, Steverin and Verbrugge, 1999). However, these self-management abilities are the resources needed to adequately manage the remaining direct resources. They help elderly people to maintain well-being, by mitigating future losses and by even improving certain resources for well-being. The theory predicts that a decline in well-being can be prevented or reduced by increasing Self-Management Ability (SMA). SMA refers to the adaptive resources needed to realize and sustain well-being. It also means the core behavioural and cognitive abilities which presumably contribute to sustainable wellbeing in later life.

2.9.1.4 CONCEPTUAL FRAMEWORK:

Theoretical or conceptual framework gives shape to ideas as well as explains graphically and in narrative form, the main dimensions to be studied (that is, key factors or variables) and the relationship among the variables. The conceptual framework for this present study is shown in Figure 1:

Figure 2.1: Diagram showing the conceptual framework of the study



In this study, the diagram above showing the conceptual framework is employed in order to explain the link among the socio-demographic characteristics of the elderly, poverty and their health wellbeing in Iwo community. The basic assumption underlying

the model is, on one hand, indicating that the characteristics of the elderly may influence their socioeconomic level, which will in turn impact their wellbeing (health status), health seeking behaviour as well as activities of daily living. This is influenced by the intervening variables in terms of the state of the economy and community characteristics among others. On the other hand, the dependent variable (wellbeing) can as well affect their socioeconomic status vis-à-vis the intervening variable.

The socio-economic characteristics of the elderly like level of education, type of marriage and occupation will influence positively or negatively their financial status as well as their well being. Also important here is the elderly educational background and past occupation, which will in turn, affect their financial and health conditions.

Household family size was included to show the differences that exist, if any, in their financial and health status among the elderly, that is, when an elderly live alone or in company of others. The demographic factors of rural-urban migration and urbanization were introduced to examine how they influence the socioeconomic and health conditions among the elderly. That is, the movement of young family members and the elderly themselves in the event of industrialization and urbanization of communities today.

2.9.1.5 RESEARCH HYPOTHESES

On the basis of the objectives of the study, the following hypotheses guided this investigation:

1. There is no significant relationship between poverty (income) and age of the elderly in Iwo community
2. There is no significant relationship between age of the respondents and their wellbeing in Iwo community.
3. There is no significant relationship between gender/sex of the respondents and their wellbeing in Iwo community.
4. There is no significant relationship between educational status of the respondents and their wellbeing in Iwo community.
5. There is no significant relationship between marital status of the elderly and their health seeking behaviour in Iwo community.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

A very important aspect of any scientific inquiry is the modality for collecting data and arriving at conclusions on the identified research problem. The research design connotes all decisions made and steps taken in planning the study; the methods adopted, decisions about sampling, sources and procedures for data collection and analysis, modalities for measurement of variables and the overall work plan adopted (Rubin and Babbie, 2001). This chapter discusses the methodological steps taken in this research. It includes the description of the methods adopted in collecting data at every stage and also methods used to analyse the data collected. The key components of this chapter include the research design, description of the study area, study variables and indicators used in measuring them, research procedure, ethical considerations and the problems encountered during the investigation.

Contemporary thinking in social research considers arguably social reality to be so complex a phenomenon (Punch, 2001). The picture makes it multidimensional. Therefore a single instrument or perspective would prove incapable of traversing all of it. It is argued by social scientists that triangulation enhanced our ability to understand the phenomena under investigation more holistically. The process therefore underlies much of contemporary research activities and is hinged on the position that the use of multiple methods would compensate for the individual weaknesses inherent in each method. This orientation in research is not limited to the eclectic choice of instruments alone, but has implication for the development of theoretical and conceptual scheme for the purpose of explaining social and demographic processes.

3.1 METHODS OF DATA COLLECTION

The study adopted triangulation of methods by employing the survey method, in-depth interview (IDIs) and focus group discussions (FGDs). The nature of the problem necessitated combination of qualitative and quantitative methods for data collection. These included survey method (questionnaire) for quantitative data while In-Depth

Interview (IDIs) and Focus Group Discussions (FGDs) generated qualitative data. The study was conducted basically through the survey method complemented with Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs). This triangulation (combination) is important in two respects. First, it is relevant to the emerging social science temperament that provides the best means of fostering a trans-disciplinary tradition in the face of a prevailing anti-positivist ferment. Second, the study is heuristic, as shown in the literature review. The triangulation of quantitative and qualitative research strategies (Table 3.1) and their prioritization in a particular sequence was therefore from the point of view of data collection on the socioeconomic wellbeing of the elderly in Iwo community, Southwestern Nigeria.

The principal survey instrument was used to generate data that measure the distribution of certain characteristics in the population with a view to offering an explanation for their occurrence. Quantitative and qualitative methods were exhaustively used. Ordinarily, the structured interview helped to generate standardized information from a representative sample of a given population. It may be used exclusively when the investigation is not heuristic or when there is no need to relate findings to the general socio-cultural environment. In contrast to quantitative methods, however, qualitative research methods are flexible, fluid, lively, in-depth and rapid assessment method for exploratory or pilot research into an unfamiliar, uncharted research terrain like demography of ageing. They were used to enhance the quality of findings supplied by the survey instrument and to imbue them with greater explanatory significance.

Table 3.1: RESEARCH OBJECTIVES AND METHODS MATRIX

Research Objectives	RESEARCH METHODS		
S/No	SURVEY	IDIs	FGDs
1	✓	✓	
2	✓	✓	✓
3	✓	✓	✓
4	✓	✓	✓
5	✓	✓	

Source: Fieldwork, 2007

3.2 STUDY AREA: IWO

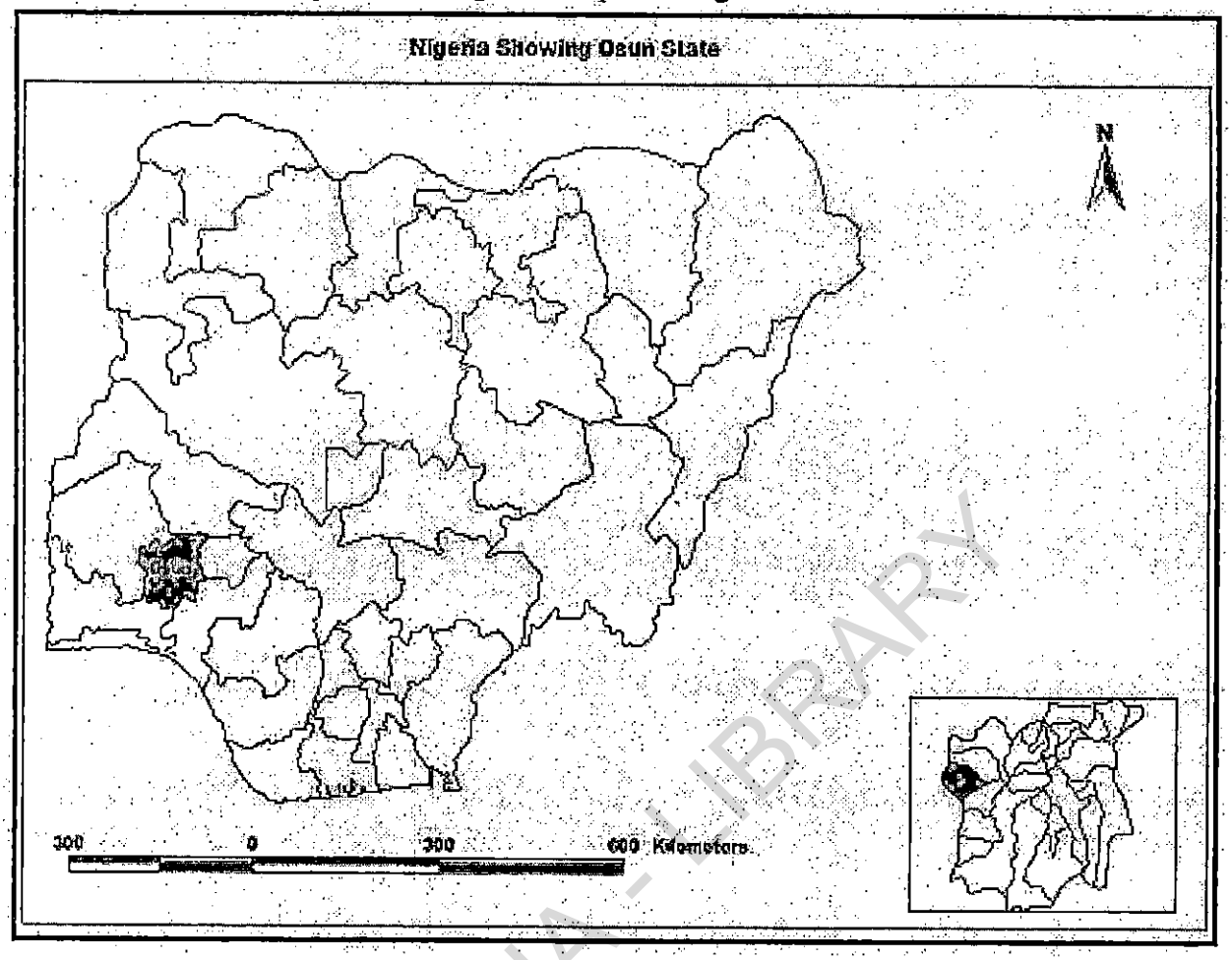
The Iwo people are said to have originally belonged to Ile Ife, from where they migrated sometime in the 14th century. The earliest settlement initiated by Telu, a prince from Ife, was first at Igbo-Orita along Ibadan-Iwo road, which was at a distance of about 5 kilometres from the present town center. After the death of Telu, Parin, one of his successors, moved to a new settlement which he called Iwo. He was installed the first Oluwo of Iwo around the 16th century. Parin divided the town into five major quarters: Oke-Oba, Isale-Oba, Oke-Adan, Gidigbo and Molete. Each quarter was under the command of a chief chosen by the Oba (Alonge, 1994).

The study was carried out in Iwo, Osun State of Nigeria. Iwo town is about 34 kilometres from Ibadan, Southwestern Nigeria. Iwo is an indigenous Yoruba town. The Yorubas are found mainly in the southwestern part of Nigeria. They can also be found all over the world and they significantly have distinct and rich cultural background. In terms of health and illness, they have cultural perception and have access to both traditional and modern health care systems. It is a Local Government Area with an indigenous and relatively homogenous community. Iwo Local Government Area (LGA), purposively chosen, is zoned into five constituencies with fifteen wards, namely Oke-Oba, Isale-Oba, Oke-Adan, Gidigbo and Molete (see Figures 3.1, 3.2 below).

The study was conducted among the elderly in Iwoland of Southwestern Nigeria. The State has 30 local government areas (LGAs), of which three comprise the Iwoland, namely Aiyedire, Olaoluwa and Iwo with total population of 40,427, 43,297 and 105,951 respectively according to 1991 population census but the recent population of Iwo is now put at 191,377 people (NPC, 2006). Iwo is located at a distance of 34 kilometers from Ibadan, 37 kilometers from Oyo, 46 kilometers from Osogbo, 33 kilometers from Ejigbo and 35 kilometers from Gbongan. It lies within longitude 4.9^0E and latitude 7.37^0 of the Equator. It comprises many villages and hamlets some of which are Agberire, Adana, Apata, Ategun, Ileogbo, Oluponna, Obajoko, Olosi, Motunase, Foko, Agbona, Papa, Kuta, Fesu, Ogburo to mention a few.

Almost 80% of the population are farmers cultivating cassava, yam, cocoa, kolanut, palm kernel among others. Other notable occupations that have generated patronage from indigenes are hunting, farming, blacksmithing, trading in assorted goods,

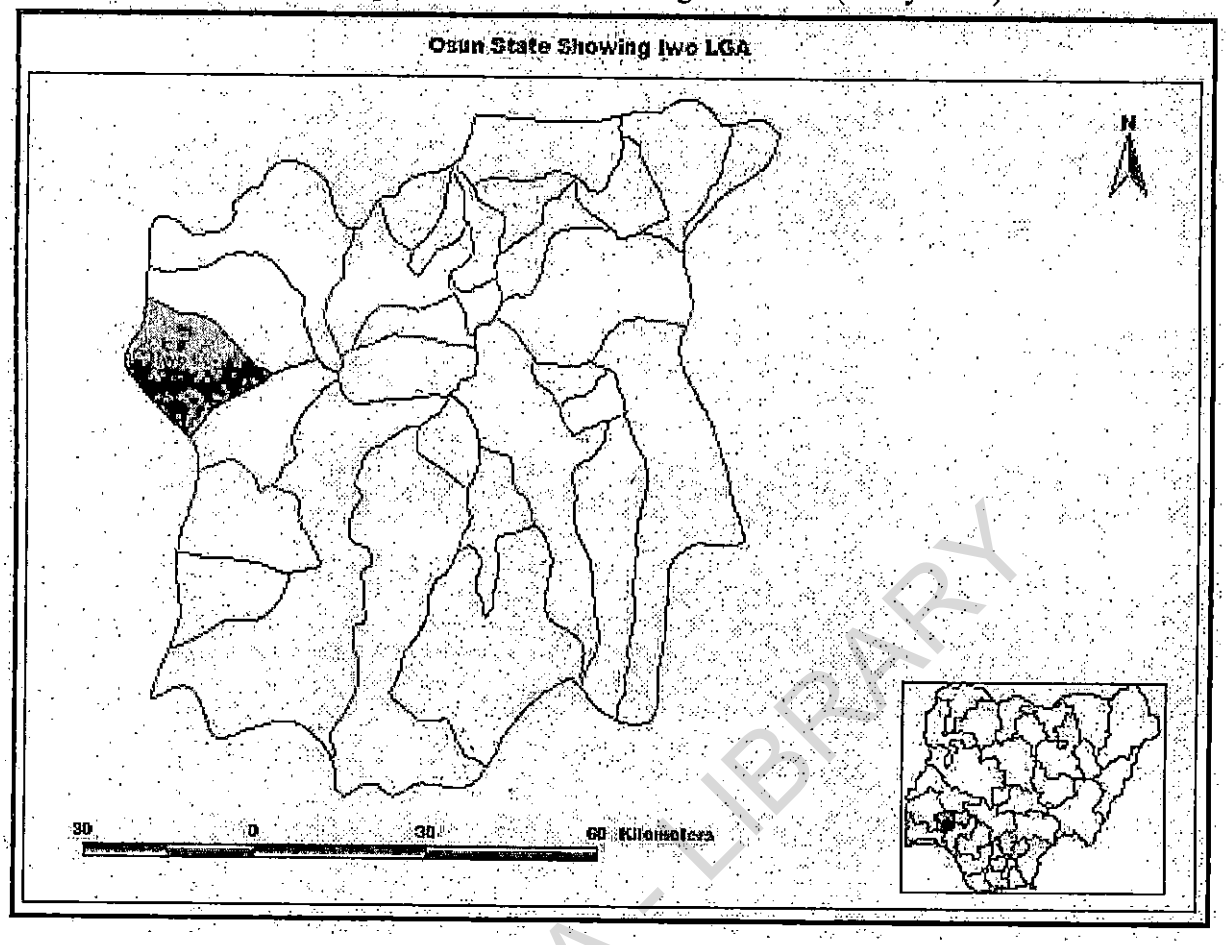
Figure 3.1: Nigerian map showing Osun State



weaving and dyeing. The people of Iwo and its environs co-exist peacefully together while believers of Christianity, Islam and Traditional religions inter-mingle among one another. In order to understand the situation of the elderly in Iwo community within the context of poverty trajectory and their wellbeing, a description of Iwo social organisation is important.

Traditionally Iwo people are predominantly farmers, traders and hunters and live, not only, in patrilineage but also in patriarchal society where age and gender take the center stage in many respects in their social relations. The elderly male occupy positions of authority and influence and responsible for directing the norms, mores and values of the society. Men are generally the heads of the family units while the wives are subordinate to husbands. Hence, the society is virilocal in residential pattern. This implies

Figure 3.2: Map of Osun State showing Iwo LGA (Study Area)



that women are mostly found in their households' compound and in domestic realm. Women are predominantly traders. Odo-ori market is a major central market.

Family setting is usually extended in nature. Most relatives are bounded by common names residing mostly in the same compound. Even those who are staying outside the compound still have obligation to the extended family. Each *agbo-ile* (compound) has an elderly male head usually referred to as *Baale*. He is a decision-maker for the compound and administratively relates and negotiates with other compounds on issues of mutual interests. The head of the compound could be summoned by the *Oba* for any matter arising on behalf of the compound.

Monogamy and polygyny are both operating in Iwo. The religion of Islam which most of them practice allows for polygyny. Christians also constitute substantial number of the Iwo population. It is observed that there is no clear religious division within the households as adherents of both religions have mingles in terms of familial relationship.

There are several mosques just as there are churches spread within the town. The Muslims constitute a majority of the town population. There also traces of traditional religion in the town. There is belief in the gods, spirits and ancestral worships. This means that the two faiths; Islam and Christianity have not eroded completely traditional beliefs.

Significantly, religious beliefs might influence the conception of health and illness among the people. There could be attribution of aetiology to natural, supernatural and mystical forces (based on the beliefs). Specific and general beliefs could influence health and illness behaviour among the people. This could explain the belief in the utilization or non-use of either of the traditional or modern health facility. Moreover, there is a shrine where people can consult the gods and worship their ancestors in order to avert the occurrence of calamities, induce favour and even seek for cure for ailments. It is important to note that certain cultural beliefs may influence people's health and illness behaviour among the people. This Yoruba cultural heritage has important implications for health behaviours.

Iwo town has also embraced Western education. With the construction of a rail way station in 1909, there was an influx of Europeans missionaries who initiated the development of western education in the land. Thus, there was tremendous development of western education by the Christian missionaries, which was later complemented by Islamic organisations. The literacy level still needs to be improved as there are still many indigenous people who do not possess the basic educational qualification, even though there are many primary, secondary and a private university (Bowen University) in the town. The higher institution has made significant contribution to the development of the town with students from all over the country. Education plays an important role in shaping the disposition of the people. It also influences the individual's conception of health and illness.

There are both modern and traditional healthcare facilities in Iwo. The State General Hospital and the Baptist Dispensary account for the treatment of a large percentage of the people. There are also a number of maternity clinics. A visit to Odo-ori market revealed that there is a large section for the sale of traditional ingredients of

healthcare and even along some of the streets within the town. This signifies that residents utilize both traditional and modern medicine.

3.3 STUDY POPULATION

The study sampled all identified Iwo men and women aged 60 years and above. The Nigerian town of Iwo was purposively selected because it offers a good case of people returning home after sojourning outside their hometowns for several decades for one reason or the other in the name of old age or retirement. This also reflects the cultural pattern in other parts of the country. To buttress this, Olurode (1984:114) noted that the rejection of certain politicians at these elections did not reflect opposition based on class but a reaction to the failure of most of them to divest government resources and bring amenities to their hometown (Iwo) for development and preparatory for the time when they would leave office.

3.4 SAMPLING PROCEDURE AND SAMPLE SIZE

A survey requires a sample i.e. a cross-section of the entire population which is expected to be adequate and representative of the entire population. The choice of sample size normally involves balancing the demands of analysis with the capability of the researcher and the constraints of funds (Macro International Inc., 1996). A list of the enumeration areas (EAs) and the wards were sourced from the Local Government Secretariat. There are 134 EAs on the list in Iwo LGA divided into 15 wards. An EA is a statistically delineated geographical area carved out of a locality (or a combination of localities) with defined and identifiable boundaries. There are about 500 persons per EA and elderly persons constitute about 7% of the population in each EA. Hence there are about 35 elderly persons in each EA. About 75 EAs were randomly selected from the list and the study covered 20% of the elderly in each selected EA. Hence, the number of elderly persons that were interviewed in each of the selected EA was:

$$20/100 \times 35/1 = 7$$

Then, 7 elderly persons x 75 EAs

Having determined the number of the elderly respondents in each EA, the next phase was the selection of households for sampling. Each EA had about 72 households.

Out of every 12 households one was selected using systematic random sampling technique. A Table of random numbers was used in selecting the *n*th household, after the first household had been selected using the same instrument. The probability of each household in the selected EAs being sampled was thus:

N=TNH/Snh

Where N = selection interval

TNH = Total number of households in each of the EAs

Snh = selected number of households in each selected EAs

The above ensured that every household in the selected EAs has equal chance of being selected. After a household was selected, the next phase was to select an eligible respondent. In situation whereby a selected household had no elderly person, the next household was selected. In sum, thirty-five elderly persons were selected using random sampling of households containing at least one elderly person in each ward. This resulted into a sample size of 525 respondents.

3.5 RESEARCH PROCEDURE

3.5.1 Selection and Training of Field Assistants

A total of eleven (11) research assistants were recruited for the study. All of them were community residents with a wealth of experience in data collection. They were secondary school leavers with social research experience and a retired government worker as the supervisor. Being community members they were able to locate compounds and streets easily. Two days of training were held for all the field assistants. First day of training focussed on skills relating to identification of a household, documentation of compound structure in the study area, different sampling techniques and methods used and instruments. The second day of the training involved role-play after which the field assistants participated in a pre-test data collection exercise. The purpose of the training was to improve their interviewing skills, intimate them about the nature and methods of the study and improve their rapport building skills needed in the research study.

3.5.2 Fieldwork and Supervision

All interviewers were made to report every morning at an agreed meeting point where questionnaires were distributed. There was a Supervisor who assisted the Researcher on fieldwork. The supervisor was well known in the community with a wealth of experience in social research and had worked in the study community previously. Some of his responsibilities were to organise the ten field assistants (5 males and 5 females) and to allocate them to appropriate blocks and compounds in the community. He was always in the field and assisted whenever they had problems. The main fieldwork commenced two days after the pilot study on the 22nd August and lasted a period of seven weeks (although the research team did not work on all the days).

3.5.3 Pilot Study of the Methods and Instruments

A pilot study was conducted and pre-tested in Oluponna village, very close to Iwo community. The pre-testing and pilot study were done in order to determine the understanding of the questions by the respondents, appropriateness of the duration of the interview, appropriateness of the sequencing of the questions and the potential logistic problems that may arise during the data collection. The pilot study created the opportunity to sharpen the research assistants' interviewing skills. The lessons learnt from this exercise afforded the researcher the opportunity to revise the IDI guide, FGD guide and the Household Survey Questionnaire.

3.6 RESEARCH INSTRUMENTS

3.6.1 Survey (Questionnaire)

The survey method used was the structured questionnaire, which consisted of close-ended and open-ended questions. The structured questionnaire requested for socio-demographic information on social security, child support and care, financial and health status and usage of health facilities. It also assessed level of poverty; perceived determinants of old age poverty and the influence of all these on the wellbeing of the elderly in Iwo community.

The structured questionnaire was developed after a pilot study was conducted through indepth interview and discussions from the focus group discussion. It was pre-tested and modified to capture all the quantitative indicators outlined in the measurability

of the main concepts. The structured questionnaire contained 65 pre-coded responses and 10 open-ended questions. It was well-worded and easy to interpret. It took an average time of 50-60 minutes to administer each questionnaire. Ten field assistants were trained to administer the questionnaire. They were all indigenes of the study area to cover the five constituencies of the entire Iwo LGA. To minimize errors in data collection, field assistants were triangulated across the constituencies of the study area.

The questionnaire was divided into three modules:

1. Socio-demographic characteristics of respondents
2. Economic/financial status of respondents
3. Wellbeing/health status of the respondents

The first section sought information on respondents' age, marital status, occupation, religion, sex and educational status among others. Second section of the questionnaire was on income level, perceived determinants and perceptions of poverty, child support system among others. Third section included information on types of health problems, health seeking behaviour and recommendation to improve the socioeconomic wellbeing of the elderly among others.

3.6.2 In-Depth Interviews (IDIs)

In all, twenty (20) respondents were interviewed. IDIs were spread across different wards so that data generation was not geographically one-sided. At least, two IDIs (one for male and one for female) were conducted in ten wards randomly selected for the fifteen wards in Iwo community. This ensured adequate geographical spread and disparities in the community. Those selected were literate and non-literate men and women in the study area. Table 3.2 shows the categories of the respondents interviewed.

Table 3.2: Categories of Elderly in IDIs

No. of IDIs	Education Categories	Gender
10	Literate	Women
10	Non-literate	Men

Source: Fieldwork, 2007

The selection of the elderly was varied by education and gender. Education and gender of the elderly could affect their health seeking behaviour and conception of poverty.

3.6.3 Focus Group Discussions (FGDs)

FGDs were employed to complement the IDIs, which produced data on the subject matter as per individual respondents, thereby isolating the social context that influence the manifestation of poverty and their wellbeing and that could not be obtained through structured questionnaire. Five FGDs comprising of 6-8 elderly persons were conducted in each constituency. This allowed for interactive group sessions which provided group insights and dynamics which could not be obtained at the level of individual.

The FGDs were aimed at examining all the empirical objectives of the study. Hence, a relatively homogenous group was selected for each of the FGDs. The Researcher conducted four enhanced FGDs in each of the five constituencies of the study area. Education of the respondents was also stratified (among literate and non-literate) and varied in the FGDs. Education could affect people's dispositions in different ways. It could significantly affect the conception of health and illness. It could also determine wellbeing and illness behaviour among the people.

Table 3.3: Categories of Elderly in FGDs

No. of FGDs	Education Categories	Gender
1	Non-literate	Women
1	Non-literate	Men
1	Literate	Men
1	Literate	Women

Source: Fieldwork, 2007

The conduct of FGDs maintained geographical spread. Hence, four FGDs were conducted in each of the five constituencies of the study area. This produced complementary data to the survey of the respondents. Each FGD lasted for about 40-55 minutes. All the sessions were conducted in the local language to ensure adequate understanding among the respondents. All the sessions were held in conducive environment devoid of distractions. The time of discussion was structured to the

convenience of the group members. The ring-form sitting arrangement was maintained throughout the FGDs. This did not make any of the participants to be disadvantaged in terms of sitting arrangement in contributing to issues. The tape was always placed in the middle monitored by the facilitator and the note taker. Most of the FGDs were conducted with the help of a researcher assistant who were in charge of note-taking. A pre-test was carried out to familarise the research assistants with the instrument and to revalidate the instruments. The Researcher was personally present to facilitate the sessions. After the FGDs sessions, translation and transcription were done immediately after the session. In all, 20 FGDs were conducted; 4 FGDs in each of the 5 constituencies in Iwo community by education and gender.

3.7 INDICATORS FOR MEASURING ELDERLY POVERTY AND WELLBEING

The purpose of Operationalization or measurement of concepts ensures control over the properties and characteristics of the investigated phenomena by identifying the key variables that make up the units of analysis. It is to assign empirical and logical meanings to concepts in precise way such that measurability and replication of the study 1is possible (Hoover and Donovan 1995). Poverty and wellbeing in the study are assessed using a household level index that utilizes information about the ownership of a series of assets. The study emphasized the importance of using a set of indicators to describe poverty and health conditions of elderly persons in Iwo, given the controversies and relative nature surrounding such complex concepts and their measurements like health and poverty.

Poverty in this study is conceptualized as *wealth/economic inequality.* Its assessment questions relate to different aspects of economic wellbeing as well as ownership of assets/properties. The study adopted a household wealth index widely used in recent analyses that consider poor countries (Evans & Miguel, 2007; Boyle *et al.*, 2006; Rutstein and Johnson, 2004). The current study employed a measure based on a household wealth index conceptualised by Rutstein and Johnson (2004). The study considered whether or not the house or household in which an elderly person lives contains the following assets namely radio, television, jewellery, motorcycle, fan, telephone or refrigerator. An index was constructed following Filmer and Prichette (2001) and each variable is dichotomized as 1 if present and 0 if not. Household wealth index has a number of advantages as an

indicator of living condition and economic wellbeing among elderly individuals as well as a means of examining wealth inequality (i.e. poverty), particularly within this study population. First, it is a more permanent indicator of wellbeing than the Income or Consumption measurement. This is particularly the case with the elderly, who are often retired and hence do not earn current income. Second, it is fairly easily measured in surveys through questions about assets or properties ownership. These questions, as wealth inequality (poverty) assessment indicators, were scored on a scale.

Wellbeing: Four separate components of health derived from the disablement framework conceptualized by Verbrugge and Jette (1994) and World Health Organization (1980) are used as health outcome measures. *Health symptoms* is the first, When constructing the instrument, it was observed that asking questions about diagnosable diseases would be unproductive given that doctor visits are uncommon for this population and diseases often go unreported and undiagnosed. Instead, respondents were read a list of easily recognizable symptoms thought to relate to specific diseases and were asked whether symptom was experienced during the past month. The list includes joint pain (arthritis), headaches, fever, chest pain, coughing, breathing problems, trembling hands, diarrhea and stomach aches among others. The second measure is *Impairments*. Respondents were asked specifically about two sensory impairments eyesight and hearing capacity. The third is *functional limitations*. Respondents were read a list of these and asked whether they have difficulty conducting the activity personally and if so, the degree of difficulty (a little, a lot or cannot do). The last component is *disabilities*. This includes items otherwise known as activities of daily living (getting up from bed, bathing, eating and dressing) which are tasks necessary for daily self maintenance (Katz et al 1963). Respondents were asked whether they had a difficulty, and if so, the degree. For each health component, a dichotomous summary measure was constructed. Hence, a measure indicated whether an elderly person reported less than six or more six symptoms. For the other three components, the summary measure indicates whether one or more problem was reported. A sensory impairment means reporting either seeing or hearing problems or both. A functional limitation means reporting a lot of difficulty with or being unable to

perform one or more task. A disability means reporting any difficulty with at least one activities of daily living (ADL).

3.8 METHODS OF DATA PROCESSING AND ANALYSIS

The field exercise was followed by screening, editing and coding of copies of the instrument used for the survey. Data entry followed these stages. For this, the Statistical Package for Social Sciences was employed. Afterwards, analysis of the data was done by presenting univariate tables of simple frequencies and percentages. This was employed in describing the background characteristics of the respondents. They were used to analyse socio-demographic characteristics such age, sex, income, religion, marital status, educational attainment, types of occupation, number of children, types of marriage among others.

In order to go beyond mere description of observations, the bivariate analysis included cross tabulations that were used to compare demographic variables like age, types of marital union, number of children, income, types of occupation, educational attainment and wellbeing of the respondents. The Researcher also employed multivariate analysis by using logistic regression to test the research hypotheses and to compare odd ratios for intended and unintended economic and health seeking behaviour of the respondents. Qualitative data were incorporated into explanations given to results of the statistical tests.

The qualitative data collected through tape recorded IDIs and FGDs were analysed using ethnographic summaries and manual content analysis. Responses were presented as they were said and logically interpreted putting into consideration the social context of the participants. The manual content analysis started with transcribing, checking and editing the collected data. The second stage was the coding of the transcribed information. After transcribing and coding, three techniques of manual content analysis were adopted: The first was the summarising content analysis in which less significant or unimportant sentences and phrases were removed while important and similar sentences and phrases were merged thereby reducing transcribed materials and rendering them more valuable to the study.

The second was explicative content analysis, which clarified expressions that contradicted one another by providing reasons for such contradictions in attitude and behaviour regarding economic situation and health behaviour. The third was structuring content analysis which involved internal filtering of materials derived directly or indirectly from the summaries and explicative content analysis.

3.8.1 ETHICAL CONSIDERATIONS

Sociologists, like other scientists, have specific standards in conducting research. Failure to adhere to these principles in inquiries often reduces the level of acceptance enjoyed by the research. Basic principles include objectivity, integrity, respect for the respondent's right to privacy and dignity, protection from harm, confidentiality and informed consent. In view of the nature of the study, consent forms were given to respondents who filled survey instrument as well as those who participated in IDIs and FGDs. Consent of all involved were sought at different levels. Individual consent was sought at the household level and at the interviewers' level. Community consent was sought at the level of the traditional leaders and LGA officials. A common consent was sought from FGD participants. This way, the researcher ensured that no information was supplied by any respondent ignorantly or under duress.

The study did not expose respondents to any physical harm or damage. However, the researcher and field assistants ensured that exacerbation of the past emotional harms expressed mostly by women was avoided even as they recall unpleasant or traumatic events. Respondents were assured of confidentiality of their participation. Participants were informed about the benefits of participating through significant persons and groups. By the way of social responsibility, the study findings shall be made available not only to the academic community through journal publications, but also to the larger society through newspaper publications. In addition, if funds can be secured, short presentations in form of documentaries shall be made available to the public through the television which reaches a wider audience.

3.8.2 PROBLEMS ENCOUNTERED

The study faced a number of challenges, the most daunting being financial problem. The remuneration of members of the research team and the provision of materials, among others, needed for the study ran into some hundreds of thousands of naira. This was taken care of with the University of Ibadan Postgraduate School Scholarship (UIPGSS) that subsidized the researcher's tuition fees for the first two seasons and CODESRIA Small Thesis Grant and with the researcher's personal funds. It should also be reported that despite this constraint, some of the respondents and LGA officials demanded monetary compensation.

Besides this general financial challenge, interviewers had to content with impatient respondents, many of whom because of their advanced age considered the research instrument too lengthy and time-consuming. Many of the elderly could not bear the stress of continuous long period of 50 – 60 minutes of interview. To solve this problem, interviewers were advised to be as friendly as possible.

Questions relating to age, income and number of children, among others, were problematic for respondents to answer. The interviewers were advised to encourage them to recount their life story or tell stories of themselves, their children and family members and be observant. It was also not possible to track down the majority of the respondents at first visit. The interviewers therefore had to make repeat visits. In spite of all the problems discussed, the research exercise was successful.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 INTRODUCTION

Data from the survey are herewith presented, analysed and interpreted with the hypotheses tested. Findings from the IDIs and FGDs are also employed to complement the survey. This is done in seven parts. This first part presents data on the socio-demographic characteristics of the population. In other words, it focuses on the basic profile of individuals in the sample which formed the basis of the analysis, interpretation and discussion of findings. They include age, level of educational attainment, religious affiliation, income level, marriage type, marital status, and family size among others. Others include possession of assets e.g. house, type of work, and sources of income and places of care or treatment when indisposed. In the second part of this section, poverty among the elderly is presented using both income and non-income measures. The third part discusses the respondents' perceptions of the concept of poverty. The fourth part presents the respondents' perceived determinants of poverty while the fifth part examines the wellbeing or health challenges of the elderly. Sixth part analyses the interplay of poverty and wellbeing of the elderly. In the last part of this section, multivariate analysis and test of hypotheses are presented.

The survey data in Table 4.1 below reveals the gender composition of the respondents; elderly men constituted 35.8% while the elderly women make up more than half of the population (64.1%) as indicated across the age groups. The Table also showed the age composition of respondents; one hundred and eighty-six of them (35.4%) were between ages 60 and 64. This is followed by those who were between ages 65 and 69 with one hundred and fifty-three (29.1%). One hundred and fifteen respondents representing (21.9%) and seventy-one representing (13.5%) of the population were aged 70 years and above.

Table 4.1 presents the socio-demographic characteristics of the respondents in Iwo community.

Table 4.1: Socio-Demographic Characteristics of the Elderly in Iwo community

	MEN		WOMEN		TOTAL	
Age (in Years)	N=188	% = 35.8	N=337	% = 64.1	N=525	100%
75 and older	30	15.9	41	12.1	71	13.5
70 – 74	37	19.6	78	23.1	115	21.9
65 – 69	62	32.9	91	27.0	153	29.1
60 – 64	59	31.3	127	37.6	186	35.4
Marital Status						
Married	127	67.5	172	51.0	299	56.9
Widowed	52	27.6	155	45.9	207	39.4
Separated/Divorced	6	3.1	8	2.3	14	2.9
Never married	3	1.5	2	0.5	5	1.4
Marriage Type						
Monogamous	78	41.1	81	12.1	159	30.2
Polygynous	110	58.4	256	75.8	366	69.6
Religious Affiliation						
Christianity	72	38.2	109	32.3	181	34.5
Islam	104	55.3	211	62.6	315	60.0
Traditional	12	6.3	17	5.1	29	8.6
Educational level						
No formal education	88	46.8	204	60.5	292	55.6
Primary school	58	30.8	87	25.8	145	27.6
Secondary school	29	15.4	37	10.9	66	12.5
Tertiary education	13	6.9	9	2.6	22	4.1
Employment status						
Worked within last 12 months	34	18.0	146	43.3	180	34.2
Currently employed by others	10	5.3	15	4.4	25	4.7
Currently working for self	17	9.0	122	36.2	139	26.4
Not Working Now	127	67.5	54	16.0	181	34.4
Occupation most of life						
Agriculture	152	80.8	259	76.8	411	78.2
Others	36	19.1	78	23.1	114	21.8
Household Size						
1 – 2 children	27	14.2	59	14.5	86	16.3
3 – 5 children	77	40.9	151	44.8	228	43.4
6 or more children	84	44.6	137	23.1	221	42.0

Source: Primary Data, 2007

Considering the cultural value attached to individual age, particularly among the Yorubas in Iwo community, the distributions on age must be treated with caution because according to Wahab (2005) age reporting in developing countries is problematic in that people because of ignorance or reluctance to state their actual age and societal attitude to age, are more likely to report younger ages. Also due to early marriage, poor nutrition, extensive farming practice and lack of adequate medical services, respondents are likely to age faster than expected; making them look older. Hence the age groups of the respondents who could not give the actual age were estimated based on certain past historical events or happenings cited by the respondents. For instance, an elderly male recounted this when asked about his age:

> *I might not know the exact day and time of my birth but I remember that my parents were happy about my success, completing primary six back then because I was among the first set of students in the First Baptist Primary school here.*

The First Baptist Olukotun Primary school was discovered from investigation to be the first primary school established in Iwo in 1952. Thus, the age of the respondent was estimated to be between 65 and 69 years of age as at the time of this study.

On marital status of the respondents, two hundred and ninety-nine respondents (299) representing 56.9% of the total sampled respondents were married. Two hundred and seven (207) representing 39.4% were widowed. The married men were 127 (67.5%) while married females were 172 (51.0%). The low number of divorced / separated respondents could be attributed to the rarity of divorce among the Yoruba, which constitutes one of the dominant ethnic groups in the country.

Table 4.1 shows that 366 respondents of the total sample representing 69.6% were in polygynous type of marriage while the remaining one hundred and fifty-nine representing 30.2% were in monogamous marriage. This is probably because the sampled respondents belonged more to the Islamic faith (60.0%) than Christianity (34.5) and Traditional religion (8.6%). This confirmed the general belief that the study area is more of an Islamic society. Iwo is generally referred to as *Ilu Awon Alf*a meaning 'the abode of Islamic Priests'. Islam permits the man to marry more than one wife.

Also, three hundred and fifteen respondents Muslims, representing 60.0% of the total were interviewed and one hundred and eighty-one Christians, representing 34.5%

were interviewed and twenty-nine Traditionalists representing 8.6% were interviewed. The distribution of respondents' level of education revealed that three hundred and twelve respondents representing 59.4% of the total population had no formal education. When disaggregated according to gender, men were found to possess higher educational qualifications than women. This suggests that the level of literacy is higher among the male respondents than the females.

The survey data also revealed the employment status of the respondents. One hundred and eighty-one respondents representing 34.4% are currently unemployed, but are living on care and support from adult children and relations. Respondents who were not currently working at the time of the study attributed their situation to unavailability of job opportunities for them and ill-health among others. This may adversely influence the socioeconomic wellbeing of the elderly people. Four hundred and eleven respondents representing 78.2% of the total sample of the population are still working in informal settings and non-pensionable jobs such as farming and hunting and the likes while a few of them representing 21.8% worked in other areas of the economy such as education and the civil service.

On the household size, it showed clearly that the elderly lived in the company of others. Two hundred and twenty-eight respondents representing 43.4% of the total population live in households having between 3 and 5 children staying with them. Also, two hundred and twenty-one respondents (42.0%) live in households having six or more children.

4.1 POVERTY AMONG ELDERLY PEOPLE IN IWO COMMUNITY

In this study, two methods were used to examine the poverty level among the respondents following its relative and multidimensional nature. A single variable cannot do justice to its measurement or analysis. Hence, two methods were used namely the income indicator and non-income indicator.

4.1.1 Using Income Measure

In the first method, the study participants were asked questions to reveal their monthly income (Table 4.2). The study showed that majority of the respondents (74.2%) earned below N1000 per month. Further investigation and descriptive analysis revealed

that majority of the respondents worked were self-employed, worked for family or religious organisations and that the main source of their income was trading in agricultural products. Also, more elderly females (83.3%) earned less than N1000 than their elderly male counterparts (57.9%). Using the conventional International Poverty line of US $1 per day, which translates to N128 per day, the respondents earned less than it. This suggests that there exists a high level of poverty among the elderly in this study population in Iwo community. This affected their wellbeing socially, financially, psychologically and health-wise because they hardly participate in community development projects and take good care of themselves among others.

Table 4.2 presents below the percentage distribution of respondents by some selected socio-economic characteristics to further display their financial status.

Table 4.2: Percentage Distribution of Respondents by Selected Socio-Economic Variables

	MEN		WOMEN		TOTAL	
	N=188	% = 35.8	N=337	% = 64.1	N=525	100%
Total Monthly Income						
Below N1000	109	57.9	281	83.3	390	74.2
Between N1001-N5000	63	33.5	52	15.4	115	21.9
Between N5001 and above	16	8.15	4	1.18	20	3.80
Is your monthly income regular						
Yes	79	42.0	103	30.5	182	34.6
No	109	57.9	234	69.4	343	65.3
Is your monthly income adequate						
Yes	39	20.7	61	18.1	100	19.0
No	149	79.2	276	81.8	425	80.5
Are You a Pensioner						
Yes	22	11.7	31	9.1	53	10.1
No	166	88.2	306	90.8	472	89.9
Source(s) of other Income						
Earning Pension	22	11.7	31	9.1	53	10.1
Income from current work	64	34.0	48	14.2	112	21.3
Property / Assets e.g Rents, Shares	23	12.2	7	2.0	30	5.7
Support from Adult Children	57	30.3	209	62.0	266	50.6
Income in kind from other sources	22	11.7	42	12.4	64	12.1

4.1.2 Monthly Income and Regularity of Income

The study attempted to find out the monthly income of the respondents. The distribution of responses showed that income was generally low and that they depended on support from others, especially their adult children and relatives and even neighbours. Three hundred and ninety respondents representing 74.2% of the total population sample earned below N1000 monthly (Table 4.2). Further investigations revealed that 65.3% of the respondents do not have a regular source of income. Majority of the respondents including older men and women (34.2%) have worked at some points within the last year of the study mainly in agriculture, fishing and petty trading (Table 4.1).

The distribution showed that a majority (65.3%) of the respondents reported they were not having regular income. When asked about the adequacy of income, a substantial number of respondents (80.5%) said the income was inadequate to cater for their immediate material needs. Table 4.2 showed the total income of the respondents from all sources per month. Out of the total sample included in the study, 390 respondents (74.2%) reported having income below N1000 per month. This is followed by those whose income was between N1001 and N5000 per month with a total number of 115 respondents (21.9%), while only 20 of the respondents (3.80%) reported having a monthly income of more than N5000 and above. Further analysis of the distribution by gender showed that very low income was prevalent among females than males. Two hundred and eighty-one female respondents (83.3%) reported having a monthly income of less N1000 compared to 109 (57.9%) males.

Efforts were also made to investigate respondents' sources of income. Various sources were mentioned which included pension (10.1%); property leasing such as rents and shares (5.7%); income in kind (12.1%); income (salaries/wages) from current work (21.3%) and support from adult children (50.6%). When further disaggregated by gender, some interesting patterns emerged. The data revealed that males (30.3%) indicated that their main source of income was support from adult children as against females (62.0%) who reported same. More women got more care and support from their adult children than men. This is followed by salaries /wages (21.3%) of the total sample of the population, who still work in the informal settings. Table 4.2 also revealed that a

substantial majority of the elderly respondents of the sample were not pensioners (89.9%) and very few of them relied on pension (10.1%) as a source of income.

4.1.3 Level of Income of the respondents

The study asked the respondents to state their level of income with the view of examining their financial status. Income is a good measure of financial wellbeing. Table 4.3 shows their levels of income and the effects of selected socio-demographic variables of the respondents. Their levels of income are categorised into three with reference to Table 4.2. Low income represented those with less than N1000 monthly. Medium income represented those who earned between N1000 and N5000 monthly while high income represented those with more than N5000 monthly.

Table 4.3 Percentage distributions of level of income of the respondents by selected socio-demographic variables

VARIABLES	MALE				FEMALE			
	Low	Middle	High	Total	Low	Middle	High	Total
Age (in years)								
75 and older	22(73.3)	7(23.3)	1(3.3)	30	32(78.0)	8(19.5)	1(2.4)	41
70 – 74	18(48.6)	17(45.9)	2(5.4)	37	60(76.9)	16(20.5)	2(2.5)	78
65 – 69	38(61.2)	21(33.8)	3(4.8)	62	84(92.3)	5(5.4)	2(2.1)	91
60 -64	31(52.5)	20(33.8)	8(13.5)	59	105(82.6)	18(14.1)	4(3.1)	127
Marital Status								
Married	51(40.1)	64(50.3)	12(9.4)	127	59(34.3)	94(54.6)	20(11.6)	172
Widowed	20(38.4)	29(55.7)	3(5.7)	52	47(30.3)	89(57.4)	19(12.3)	155
Separated/Divorced	6 (66.7)	2(22.2)	1(11.1)	9	5(50.0)	3(30.0)	2(20.0)	10
Religious Affiliation								
Christianity	27(37.5)	35(48.6)	10(13.8)	72	62(56.8)	40(36.6)	7(6.4)	109
Islam	45(43.5)	51(49.0)	8(7.6)	104	124(58.7)	81(38.3)	6(2.8)	211
Traditional	4(33.3)	6(50.0)	2(16.6)	12	9(52.9)	6(35.2)	2(11.7)	17
Educational Status								
Non-literate	73(67.5)	26(24.0)	9(8.3)	108	136(66.7)	60(29.4)	8(3.9)	204
Literate	21(26.2)	44(55.0)	15(18.7)	80	44(33.0)	68(51.1)	21(15.7)	133
Family Size								
1-2 children	12(44.4)	9(33.3)	6(22.2)	27	28(47.4)	21(35.5)	10(16.9)	59
3-5 children	26(33.7)	41(53.2)	13(16.8)	77	38(25.1)	84(55.6)	29(19.2)	151
6 or more children	19(22.6)	56(66.6)	9(10.7)	84	39(30.7)	76(59.8)	12(9.4)	127
Occupation most of life								
Agriculture	61(40.1)	68(44.7)	23(15.1)	152	65(25.0)	151(58.3)	43(16.6)	259
Others	21(58.3)	12(33.3)	3(8.3)	36	38(48.7)	33(42.3)	7(8.9)	78

Note: *P<0.05, **P>0.05. Low income = [below N1000], Middle income = [between N1000-N5000], High income = [above N5000]

It is apparent from Table 4.3 that the majority of the respondents (74.2%) across the different age groups reported more low level of income than medium (23.8%) and high (4.1%) levels of income. This could be due to the fact that the study area is characterized by low-middle income and poor industrial economic activities. The implication is that there are very limited employment opportunities for people and even for the respondents, who may still want to continue to work in this community.

On the age level, elderly males who are aged 75 years and older reported lower levels of income (73.3%), 45.9% of those within the age bracket 70-74 years reported middle level of income while those in age group 60 - 64 years reported (13.5%) high level income. On the female column, 82.6% of those aged 60 - 64 years reported lower levels of income; those within the age group 70-74 years (20.5%) reported middle level of income while 3.1% of those in age bracket 60-64 years reported high level income. It is observed that those in age bracket 75 years and older reported lower level of income than those aged 60 – 64 years. Possible explanation for this could be that as they get older the respondents experienced declines in income and other resources.

In terms of marital status, those who are married (50.3%) and widowed (55.7%) reported middle level of income than those separated/divorced (22.25). This pattern is observed for male and female respondents on the Table 4.3. Possible explanation for this may be due to support and care from adult children and relations. On religious affiliations, Traditionalists (50.0%) and Muslims (49.0%) and Christians (48.6%) reported middle level income on the male column unlike on the females' column. Also those who are Christians (13.8%) and traditionalists (16.6%) reported higher levels of income than the Muslims (7.6%). A similar pattern applies to the females' column. This may result from financial support from their spiritual/religious circle of fellow believers.

On the educational level, educated male respondents generally have middle level income (55.0%) than males without education, who generally have low income (24.0%). This is similar pattern applies to the females' column. Possible explanation for this might be due to their educational qualifications/skills, which could be converted to financial/economic empowerment unlike those without education. In terms of family size, 44.4% of those with 1-2 children reported having lower levels of income, unlike those with 3-5 children (53.2%) and those with more than 6 children (66.6%), who reported

middle level incomes on the males' column. A similar pattern applies to the females' column. In other words, those with more children had more income, probably with support from their adult children in the town and cities.

Table 4.3 showed that most of the respondents who worked in the agricultural sector reported generally middle level income (44.7%) and high level income (15.1%) unlike those in the other sectors with middle incomes (33.3%) and high incomes (8.3%) on the male side respectively. The same pattern is reflected on the females' column. Possible explanation could be that income from agriculture is more regular unlike those in others (non-agriculture) given the low industrial, socio-economic profile of the study population.

4.1.4 Using Non-Income Measure

The second method of poverty measurement, utilized the non-income approach. The respondents were asked to itemize their household assets so as to investigate their socioeconomic living conditions. Table 4.4 below shows further the web of relationships between the socioeconomic living conditions of the elderly respondents and their wellbeing. The respondents were interviewed to know if they possessed some essential household facilities or assets preparatory to old age. Minority of the respondents possessed very few assets such as land (5.8% for elderly males and 1.1% for elderly females), personal savings (6.3% for males and 0.5% for females), telephone (21.8% for males and 6.8% for females), motor car (14.8% for males and 2.9% for females), electric fan (16.4% for males and 19.5% for females), refrigerator (27.6% for males and 12.5% for females), motorcycle (36.1% for males and 4.4% for females), jewellery (47.3% for males and 81.0% for females). However, a substantial majority of the respondents owned a television set (70.7% for males and 59.6% for females) and a radio set (78.7% for males and 64.0% for females). This also reveals that the respondents were materially impoverished in terms of household assets or resources by gender.

Table 4.4: Percentage distribution of household assets available to the elderly

	MEN		WOMEN		TOTAL	
Which of the following household assets do you have						
Radio						
Yes	148	78.7	216	64.0	364	69.4
No	40	21.2	121	35.9	161	3.5
Television						
Yes	133	70.7	201	59.6	334	63.8
No	55	29.2	136	40.3	191	36.1
Jewellery						
Yes	89	47.3	273	81.0	362	68.9
No	99	52.6	64	18.9	163	31.0
Motorcycle						
Yes	68	36.1	15	4.4	83	15.9
No	120	63.8	322	95.5	442	84.0
Refrigerator						
Yes	52	27.6	66	12.5	118	22.5
No	136	72.3	271	87.4	407	77.4
Electric fan						
Yes	31	16.4	37	19.5	68	13.0
No	157	83.5	300	80.4	457	86.9
Car/Vehicle						
Yes	28	14.8	10	2.9	38	7.3
No	160	85.1	327	97.0	487	92.6
Telephone						
Yes	41	21.8	23	6.8	64	12.2
No	147	78.1	314	93.1	461	87.7
Land						
Yes	11	5.8	4	1.1	15	3.0
No	177	94.1	333	98.8	510	96.9
Savings						
Yes	12	6.3	2	0.5	14	2.8
No	176	93.6	335	99.4	511	97.1

Source: Primary Data, 2007

4.1.5 Household Wealth Inequality Index (HWII)

The Household Wealth Inequality Index (HWII) was employed to examine the living conditions vis-à-vis well being of the elderly in this study. The index is conceptually built on the notion that wealth is an underlying and unobservable measure relating to relative economic position within a social hierarchy. Therefore the location of a particular household within a hierarchy can be assessed through variables that provide information on whether or not a household owns or contains basic assets and structural components. This study considers information regarding whether the household contains the following: a radio, television, jewellery, telephone, refrigerator, electric fan, car, motorcycle, land and savings. Individuals are then ranked from top to bottom according to the index and divided into quintiles. A quintile is one fifth of a population. It divided the units of a frequency distribution into five classes, each containing 20% of the total number of units such that the values corresponding to the units in one class are less than the first quintile, those in a second class are greater than the first quintile and so on throughout. Thus, the index is a linear combination of the assets. Given a sample size of about 500; this means about 100 respondents within each quintile, but members are not exactly 100 due to a fair degree of heaping around ownership of certain combinations of household items.

The construction of the index then follows from Filmer and Pritchett (2001). Assets are coded 1 if owned and 0 if not owned. The contribution of each indicator to the index is determined by a principal component analysis that assumes a single factor is derived from the series of assets. Each individual in the sample then has a wealth score that has a mean of 0 and a standard deviation of 1, with the score being the result of assigning weights to each asset.

Table 4.5 presents information on the wealth index among the elderly in Iwo community. The Table shows the mean, standard deviation and the specific assets owned across the quintiles.

Table 4.5 Household Wealth Inequality Index (HWII) showing households owning specific assets, and selected demographic characteristics, by wealth quintiles

		Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
	TOTAL (N=525)	Lowest (N=62)	Second (N=71)	Third (N=115)	Fourth (N=121)	Highest (N=156)
A. Number of assets owned:						
Mean	2.44	0.0	0.45	1.58	2.88	5.57
Standard deviation	2.08	0.0	0.50	0.49	0.67	1.60
B. Household Assets:						
Radio	364 (69.4)	0.0	32 (8.7)	35 (9.6)	124 (34.1)	173 (47.5)
Television	334 (63.8)	0.0	0	82 (24.5)	94 (28.1)	158 (47.3)
Jewellery	153 (29.3)	0.0	0	0	57(37.2)	96 (62.7)
Motorcycle	83 (15.9)	0.0	0	0	25(30.1)	58 (69.8)
Refrigerator	118 (22.5)	0.0	0	0	31 (26.3)	87 (73.7)
Electric fan	63 (13.0)	0.0	0	0	17 (25.0)	51 (75.0)
Car	38 (7.3)	0.0	0	0	13 (34.3)	25 (65.7)
Telephone	64 (12.2)	0.0	0	0	15 (23.5)	49 (76.5)
Land	15 (3.0)	0.0	0	0	03 (20.0)	12 (80.0)
Savings	14 (2.8)	0.0	0	0	04 (28.6)	10 (71.4)
C. Demographic characteristics						
% Female	64.1	67.2	52.7	51.0	52.5	62.8
% In agriculture	78.2	68.5	64.7	65.3	62.5	53.2
% Living with child	62.4	35.5	44.6	55.9	75.6	80.4
Mean household size	5.4	2.1	3.5	4.8	5.6	6.5

Source: Primary Data, 2007. (Figures in parenthesis are percentages)

Row A, in Table 4.5 shows the mean and standard deviation. The overall mean is 2.4 and the range is between 0 and 5. There is a clear relationship between number of assets owned and wealth quintiles. The respondents who scored low on the wealth index are those that live in households that own none or few assets. The lowest quintile is made up of 62 respondents living in households that own none of the assets. Although in relative sense those in the second quintile have more wealth, the qualitative increase is trivial. It is made up of 71 respondents living in households that own one asset. Again, the qualitative change to the middle quintile is slight. The mean number of assets owned

is 0.45, but the range indicates nearly all of these respondents live in households with only one assets. There is more variation in number of assets owned for those in the fourth quintile where the mean is 2.88 and the standard deviation is 0.67. Lastly those in the highest quintile own between 4 and 8 assets, with a mean of 5.57 and standard deviation of 1.60.

Row B, in Table 4.5 examines the specific assets owned across quintiles. Those in the lowest quintile own no assets. The one asset owned by those in the second quintile tends to be a radio (8.7%). Those in the third quintile typically live in households that own both a radio and television. An appreciable increase in wealth quintiles is only evident for the fourth quintile. Those in the fourth quintile typically live in household that own both a radio and television and they may also have motorcycles, jewellery and fan. A notable increase in wealth is more displayed for the highest quintile. These elderly ones live in households that own a fair mixture of assets. A large proportion of this elderly population lives in very primitive housing conditions, subsists only on what they grow, and owns only a few essential items such as clothes and some cookware in the lowest quintile.

Row C, in Table 4.5 presents the demographic characteristics of respondents across wealth quintiles. The lowest quintile is made up of more women (64.1%). Those in the highest quintile are more likely to have worked in the past years than those in the other quintiles. More than 60.0% of those in the lowest three quintiles worked in agriculture most of their lives compared to about 53.2% of those in the highest quintile. The percentage living with a child increases from about 35% to 80% moving from the lowest to the highest wealth quintile, and the mean household size increases consistently from 2.1 to 6.5. Clearly more people in the household allows for an accumulation of assets, which is reflected in the wealth index. In summary, those in the highest quintile appear more likely to be educated, non-agricultural workers living in large households. Those in the lowest quintiles appear likely to be more widowed women without education, working in agriculture and living in small households.

4.2 RESPONDENTS' PERCEPTIONS/INTERPRETATIONS OF POVERTY

Results from the qualitative responses showed that there were various interpretations or perceptions of what constitute poverty among the elderly in the study area. Understandings of poverty are grouped into five categories namely ***ise*** (deprivation), ***aini*** (want or lack), ***osi*** (wretchedness or destitution), ***iya*** (suffering) and ***aibegbejo*** (inequality). Firstly, the perception of poverty among the respondents has to do with deprivation, which is referred to as ***ise*** in Yoruba language. From the responses, poverty was emphasised to mean lack of something that one needs to be healthy, comfortable and happy. In other words, poverty was described as lack of things necessary for comfortable living conditions. For instance, a female focus group discussant aged 67 remarked that:

> *... one who lacks the basic necessities of life is a poor person and this is especially severe when one is old without a house of your own or the one built by one's children*
>
> (FGD, 2007)

Another FGD female participant aged 65 described poverty as:

> *...lack of money or income-generating ventures that regularly help one to afford whatever one needs*
>
> (FGD, 2007)

In addition to the above responses, another FGD male participant added that:

> *... as we grow older, we are gradually becoming dependent on our children. Now we are in a situation that appeared that we never had children at all because they hardly come to help or assist us... just like an adage says that when a rabbit is old, it will suck its children's breast. But for lack of employment opportunities and economic hardship for our children, we are deprived of their care and support in old age* (FGD, 2007)

The above qualitative responses showed that elderly people in Iwo interpreted poverty to mean deprivation in one way or the other that incapacitate them.

Secondly, they also perceived poverty as ***aini***, which is understood as the desire or need for something which is not met. In the study area, some of the respondents expressed their need for children's support, money, food and house as poverty which remain unmet.

A male IDI respondent recounted that:

> *...usually at this age of over sixty years, a man begins to depend on his children, according to the proverb which says that old rabbit sucks his young children's breast or live on his investments. For instance, my own children, grown up and married, are far away, they hardly come home. Things could have been better if they come visiting*
>
> (IDI, 2007)

It was also observed that most times, reference is made to lack of money. A female FGD participant aged 68 remarked:

> *...ever since the demise of my husband about 6 years ago, apart from the loss of his presence, money has become my problem, my upkeep money is daily decreasing and even my children's support is becoming irregular, So I resort to begging for alms*
>
> (FGD, 2007)

Thirdly, the respondents also revealed that poverty is conceived as ***osi,*** which denotes wretchedness or destitution. In other words, poverty was understood by the respondents as not having things that are necessary in life such as a home, food and money. For instance, a male IDI respondent reported:

> *... a man is poor when he has no house to live in, just wandering about the streets without a home and without people to call his own people*

Yet another female IDI participant stated:

> *...a person, who has no worth or social value and is without properties to live on, is wretched. That is, such a person is useless to his or her self and to others around in this community. Most often such persons are without family relatives or connections*
>
> (IDI, 2007)

Fourthly, their perception of poverty has to do with what they referred to as suffering, ***iya*** in Yoruba native language. Some of the participants in a focus group discussion had this to share:

> *... a person is regarded as poor at this age when he or she is experiencing suffering, sadness, pain or difficulty in getting some things done such as carrying objects and walking around. A person who is not eating enough nutritious meals will not be happy at all. Someone with functional limitations or without children to help, at this stage is suffering and that is poverty.*
>
> (FGD, 2007)

Another female FGD respondent also elaborated as follows:

> *... because of inability to afford whatever one needs to make life worth living, especially food. If you cannot provide food for yourself or your household, then one is considered poor. A Yoruba adage says that when the problem of hunger is handled, then poverty will be getting attention*
>
> (FGD, 2007)

Fifthly, respondents' perception of poverty is known as ***aibegbejo***. This means inequality or backwardness. This translates to a state of not measuring up with one's mates or contemporaries when one is supposed to evaluate one's achievements or accomplishments with theirs.

A male focus group discussant aged 74 explained that:

> *...when a man cannot boast of grown-up children who are working and bringing goodies home; a house of his own to rest his head or the one built by his children and even giving out his daughters in marriage as his colleagues, then such a person can also be regarded as poor.*
>
> (FGD, 2007)

Yet another female participant aged 66 added:

> *...one is really poor when by now a woman of over 60 years cannot boast of having married children among one's mates or contemporaries.*
>
> (FGD, 2007)

In light of the above, the qualitative data showed that there are different interpretations of what constitutes poverty among the elderly participants in Iwo community. It is no wonder that there is not one definition of poverty that has withstood scientific rigour and this equally establishes the realities of the poor. It is possible to arrive at a confluence of perceptions that poverty is multifaceted and its causes multi-pronged.

In the same vein, Schaefer (2005) argued that attempts by sociologists and other social scientists to better understand and explain poverty are complicated by the variety of meanings that people often give to it. This problem is evident even in government programmes and policies on poverty, in either absolute or relative terms. Schaefer posited that absolute poverty refers to a minimum level of subsistence that no individual should live below it. For instance, an individual should be able to subsist on US $1 per day. Here the benchmark is that US$1 is the line of demarcation. This perhaps informed

government policies concerning minimum wages for workers, housing standards, or school lunch programmes for the poor designed to bring citizens' living condition to a predetermined level of existence. On the other hand, relative poverty is comparative. That is, a floating standard of deprivation by which people at the bottom of a society, whatever their lifestyles, are judged to be disadvantaged in comparison with those at the top of the whole society (Schaffer, 2005:211). Among the respondents, having the care and support of one's adult children is a measure of the extent of poverty among themselves. The issue of poverty among the elderly is perhaps more of relative poverty.

Beyond that, the respondents' qualitative responses can also be interpreted in terms of absolute and relative poverty. Poverty defined in absolute terms refers to a state in which the individual lacks the resources necessary for subsistence. In this respect, the respondents regarded poverty as ***ise*** (deprivation), ***aini*** (want or lack), ***osi*** (wretchedness or destitution). For example, their daily income or consumption level is less than US $1 which is the international benchmark. This implies that they lack the financial capacity to meet or provide for their material needs and otherwise. On the other hand, relative poverty refers to the individual's or group's lack of resources when compared with that of other members of the society—in other words their relative standard of living. This is a situation of inequalities in resources distribution across a society. Here it is observed that respondents without married / adult children are seen as poor, while those having married / adult children are non-poor.

4.3 PERCEIVED DETERMINANTS OF POVERTY AMONG THE ELDERLY IN IWO

This section presents the perceived causes of poverty among the respondents that resulted in old age poverty. The following points were mentioned as responsible for deepening poverty among them:

4.3.1 Lack of farmland

Non-ownership of farmland is observed to be a major problem by respondents in this community because most of them spend their lives in the informal sector working in agriculture. Hence, an elderly person without land for agricultural purposes or any other

income-generating assets is more prone to poverty. For example, a male FGD participant aged 68 said that:

> *My parents were poor by every standard you can think of ... They did not have any single asset and they could not afford to give me a farmland.*
>
> (FGD, 2007)

Another female FGD participant aged 65 added that:

> *...having a land for farming today would have been a safety cover for me but I don't have any land...I only depend my little pension and children to make ends meet.*
>
> (FGD, 2007)

The respondents considered themselves poor because they are do not have lands to cultivate crops from which to earn income and hence meet their basic needs.

> *I consider myself in poverty because I have nothing like farmland that will bring me regular money...Old age is a period of declining income as well as assets having used them over a long period of time*
>
> (FGD, 2007)

Another male IDI aged 71 participant added that:

> *If you do not possess land for either agricultural use or residential purpose, one as an elder is perceived to be poor, who has little or nothing to support himself except to depend on others for living*
>
> (Elderly IDI male, 2007)

4.3.2 Lack of Children Care and Support

Lack of children support in old age can be linked to isolation, ill-health and poverty. Qualitative data showed that an elderly person who lacked care and support from his/her adult children, especially those who are gainfully employed in the cities are often regarded as poor in Iwo community. For example, a female focus group discussant aged 69 years explained that:

> *...as parents, having no adult children to help or support will not only increase one's burden but also heightens one's sense of lack and dependence...*
>
> (FGD, 2007)

Similarly, an elderly male aged 78 years added that:

> *...I have no children around here to care and support me. Ideally, it is the duty of the family to take care of the elderly ones but things have changed these days...even the children do not want to stay with us because they believe we belong to the old generation ...*
>
> (FGD, 2007)

This can also be related to the problem of neglect suffered by the elderly as a result of the absence of their adult children and other significant others. This is linked with the wealth flow theory that posits that parents seek to have children to transfer their wealth to who (the children) will in turn take care of them in old age. This, thus, implies that adult children contribute to the wellbeing of the elderly.

4.3.3 Poor Governance/Weak Political State

Empty promises and lack of political will by government is also represented by respondents' as another perceived factor spreading poverty among the elderly in the study area. For instance, a female FGD participant aged 67 noted that:

> *...government instability is another issue. The government officials and political office holders are not interested in our wellbeing at all. They have only paid lip services from one administration to another ever since. The politicians only come to make empty promises whenever they need our votes. After the elections, whether they win or not, they are no where to be found.*
>
> (FGD, 2007)

Another male FGD participant remarked that:

> *...even the so-called pension system is not working for those who were government public servants who have spent their lifetime serving the government with nothing to show for it. There is no other programme designed to cater for the elderly in the rural areas ...they are practising selfish government for themselves, their children and family relations as well as for their friends...*
>
> (FGD, 2007)

Lack of political will and functional programmes specially designed for the elderly are considered to be creating hardship for them. This means that the government is not fulfilling its social contract to the elderly who provide their services to the larger society,

either through farming or public service. This is evidenced by non-payment of social security and the increasing number of deaths of the elderly while wanting for their entitlements.

4.3.4 Emigration of Young Family Members

Rural-urban migration of younger family members in search of greener pastures to cities is also identified as a major factor spreading poverty among respondents in this community. In the absence of labour supply of such younger people, the elderly ones are faced with many challenges. Therefore they suffer limited ability to employ paid labour. This does not only mean reduced income for the elderly, but also less productive ability to meet their subsistence needs and as such, they depend greatly on the market forces to meet their food needs. In confirmation, a male IDI participant aged 67 stated:

> *...our children who are supposed to take care of us now are no where to be found, they are not with us and they have gone to cities in search of greener pastures...*
>
> (A male IDI respondent, 2007)

Some elderly people whose children have migrated to urban areas in search of greener pastures have been deprived of the presence of their loved ones and their supportive care. A female FGD participant aged 71 confirmed that:

> *...struggling to get food and what I need is my major headache...for the past two years. They do not send me money or pay me a visit. They do not know about my wellbeing at all. The distance and their absence is a big trouble for me in getting things done...*
>
> (FGD, 2007)

4.3.5 Drought / Low Agricultural Productivity

It is observed that the income from tilling the land is often not adequate to support the elderly because of low yield, low prices of agricultural products and higher costs of growing. Low agricultural produce is also perceived as one of the determinants of poverty among the respondents. The natural ageing process, which drains physical energies, can result to low agricultural labour productivity and hence affect their ability to

cultivate the farmlands. Pesticides are also observed to be getting out of their reach because of meagre resources at their disposal.

> *Perhaps because of my age, I have difficulty in getting things done easily on the farm. I can't work long hours unlike before because of body fatigue and pains and this affects my productivity*
>
> (A male IDI respondent, 2007)

Further investigation shows that nature's vicissitude and unexpected climatic changes can have their toll on the livelihoods of people. The issue of drought came up during one of the focus group discussions. Drought was mentioned as one of the major causes of lack and suffering resulting in a shortage of food and money. One elderly male FGD participant aged 69 stated:

> *Drought is one major cause of our predicament. For instance, even if you have farmland, drought affects our yield because of lack of water. It also affects our yields from our livestock. It is hard to make progress. Anything and everything else you do is affected. We cannot do anything without water. For that reason water is important to us.*
>
> (FGD, 2007)

It can be surmised that poverty among the elderly begins from their earlier life trajectories and continues up to old age. This implies that they are more likely to spend a longer period of their lives in poverty because of low income, assets and savings, which is linked to their sources of income. Other perceived factors which operate to reduce their financial wellbeing include lack of savings, assets and skills among others.

4.4 WELL BEING/HEALTH STATUS OF THE ELDERLY

The issue of the health of the elderly is subsumed under the concept of wellbeing. This is because the question of health/wellbeing goes beyond mere absence of sicknesses or illness. It includes good residential environment, good health seeking behaviour, and availability of the other socio-economic amenities at the elderly's disposal among others. Hence, the study operationalized wellbeing of the respondents in terms of four separate health components derived from the disablement framework by Verbrugge and Jette (1994) and World Health Organisation (WHO, 1980). The health components are health symptoms, sensory impairments, functional limitations and disabilities. The study therefore asked the respondents several questions about different aspects of their wellbeing.

The Tables below show the four health components of the respondents. Table 4.6.1 shows the health symptoms among the elderly.

Table 4.6.1: Percentage distribution of health symptoms by gender

Health symptoms	Male	Female	Total
Breathing problems	53 (28.1)	62 (18.3)	115 (21.9)
Chest pain	28 (14.8)	69 (20.4)	97 (18.4)
Coughing	69 (36.7)	87 (25.8)	156 (29.7)
Diarrhoea	25 (14.8)	76 (22.5)	101 (19.2)
Fever	89 (47.3)	184 (54.5)	273 (52.0)
Joint Pain	82 (43.6)	196 (58.1)	278 (52.9)
Headaches	67 (35.6)	137 (40.6)	204 (38.8)
Stomach aches	74 (39.3)	89 (26.4)	163 (31.0)
Trembling Hands	23 (12.2)	68 (20.1)	91 (17.3)
Vomiting	71 (37.7)	96 (28.4)	167 (31.8)

Source: Primary Data, 2007. (Figures in parenthesis are percentages)

Ageing is strongly related to health deterioration. Other things being the same, the health of the elderly is expected to get worse, than that of the rest of the population. The Table 4.6.1 indicates that 21.9% of the respondents reported having breathing problems. This is followed by chest pain (18.4%), coughing (29.7%) and diarrhoea (19.2). Joint pain was found in 52.9% of the respondents, closely followed by fever (52%) and headaches (38.8%) as health problems facing them in the community. Hence, joint pains, fever and headaches are the most leading health problems confronting the respondents. A

closer look reveals that elderly female respondents have more health problems than their male counterparts. As reported in order of severity or intensity, the women reported joint pain (58.1%), fever (54.5%) and headache (46.4%) as the most prevalent health ailments affecting them, while the men reported joint body pain (43.6%), fever (47.3%) and headache (35.6%). Although they both identified the same type of health problems but in different order or combination, this may be due to their physiology and pressure of livelihood. Trembling hands was the least reported (17.3%) among the respondents; elderly men (12.2%) and elderly women (20.1%). It is showed from the Table 4.6.1 that elderly women reported more health issues than their male counterparts basically because of their physiology, pressure of household chores and care of self, children and husband.

Table 4.6.2 focuses on the sensory impairments facing the respondents in Iwo community.

Table 4.6.2: Percentage distribution of respondents by sensory impairments

Sensory Impairments	Male	Female	Total
Poor eyesight	47 (25.0)	128 (37.9)	175 (33.3)
Poor hearing	55 (29.2)	114 (33.8)	169 (32.1)

Source: Primary Data, 2007. (Figures in parenthesis are percentages)

One hundred and twenty-eight female respondents (37.9%) reported that they were having poor eye sight, which is more than the male respondents (25.0%). The same pattern is observed with poor hearing by gender among the respondents.

Table 4.6.3 presents the functional limitations facing the respondents in Iwo community.

Table 4.6.3: Percentage distribution of respondents by functional limitations

Functional Limitations	Male	Female	Total
Walking	32 (17.0)	128 (37.9)	150 (28.5)
Lifting objects	45 (23.9)	147 (43.6)	192 (36.5)
Decreased Mobility	52 (27.6)	91 (27.0)	123 (4.38)

Source: Primary Data, 2007. (Figures in parenthesis are percentages)

Thirty-two male respondents (17.0%) reported difficulty in walking, about 24% reported difficulty in lifting objects as well as 27.6% having decreased mobility. The female respondents also reported their functional limitations in the same pattern.

Table 4.6.4 presents the disability facing the respondents in Iwo community.

Table 4.6.4: Percentage distribution of respondents by disability

Disability	Male	Female	Total
Bathing	21 (11.1)	62 (18.3)	83 (15.8)
Eating	25 (13.2)	64 (18.9)	89 (26.4)
Dressing	18 (9.57)	61 (18.1)	79 (23.4)

Source: Primary Data, 2007. (Figures in parenthesis are percentages)

Twenty-one male respondents (11.1%) reported disability in bathing, eating (13.2%) and dressing (9.6%). About 18% of the female respondents also reported disability in bathing, dressing and eating (19%). This may be attributed to the natural ageing process.

Table 4.6.5 Percentage distributions reporting summary health problems by age and gender

Age	*N*	Health[a] Symptoms	Sensory[b] Impairments	Functional[c] Limitations	Disability[d]
75 and older	71	97.1	60.5	91.5	38.0
70 – 74	115	95.6	56.5	54.8	21.7
65 – 69	153	67.9	39.2	34.6	14.4
60 – 64	186	48.9	21.5	26.3	10.2
Sex/Gender					
Men	188	62.4	32.2	28.5	14.2
Women	337	75.9	43.7	52.1	19.7
Total	525	71.0	39.6	43.8	17.7

[a]Experienced six of the following within the last three months: joint pain, headaches, fever, chest pain, coughing, trembling hands, stomach ache, breathing problems, diarrhoea, vomiting
[b]Difficulty seeing without glasses and /or hearing without a hearing aid.
[c]A lot of difficulty in walking, lifting objects and moving around the house.
[d]Any difficulty eating, dressing and bathing.

Table 4.6.5 shows the percentage reporting summary of health problems by age and gender. Seventy-one percent of the respondents reported six or more symptoms, almost 40% reported a sensory impairment, about 44% reported a functional limitation and about 18% reported a disability. The percentage reporting summary of health problems increases by age across the four indicators of health (wellbeing). It is apparent from the Table 4.6.5 that those in age bracket 75 and older reported the highest number of health problems across the indicators of wellbeing. Also those respondents aged 75 and older reported the highest level of health symptoms (97.1%), sensory impairment

(60.5%), functional limitations (91.5%) and disability (38.0%). The second highest level of health symptoms were those between 70 and 74 years (95.6%) as well as across the other health components. An interesting pattern revealed that the more they get older, the more the health problems being reported. And this can be easily related with the natural process of ageing. The respondents within the age bracket of 60-64 years, who can be referred to as the youngest old compared with other age groups, reported the lowest health symptoms (48.6%), sensory impairments (21.5%), functional limitations (26.3%) and disability (10.2%).

In terms of gender, women (19.7%) are more likely to report more than six health symptoms, sensory impairments, functional limitations and a disability than the men (14.2%).

4.4.1 Health Seeking Behaviour (HSB) of the Elderly

Health seeking behaviour can be used as a good measure of the financial wellbeing of the respondents. Table 4.6.6 revealed the types of health care options utilized by the respondents. The study asked the respondents to state their health seeking behaviour and at type(s) of health care facilities they utilized during illness in the last three months.

Table 4.6.6: Health Seeking Behaviour/Patterns among the elderly in Iwo community

Health Options Used	Male	Female	Total
Hospital /Clinics	18 (6.9)	24 (7.1)	37 (7.0)
Traditional Healers / Herbalists	29 (15.4)	31 (9.2)	60 (11.4)
Medicine Drug Stores / Chemists	31 (16.4)	46 (13.6)	77 (14.6)
Spiritual / Religious / Faith Healers	38 (20.2)	119 (35.3)	167 (31.8)
Self Treatment	87 (46.2)	168 (49.8)	235 (44.7)

Source: Primary Data, 2007

Results from Table 4.6.6 show that a significant number of the respondents (44.7%) engaged in self-treatment as their first aid. This is followed by utilizing religious centres for solutions or treatment of their health problems (31.8%). About seventy-seven respondents (14.6%) visited the chemists for treatment. However, few respondents

utilized the services of traditional healers (11.4%). Hospitals/clinics (7.0%) attracted the lowest patronage.

On the gender level, female respondents reported more utilization across the various health care options available to them than male respondents, with the exception of medicine drug stores/chemists and traditional herbalists/healers. Possible explanation for self-treatment as the commonest treatment option by the elderly when sick is poverty and lack of social security and health insurance for Nigerian elderly persons.

In line with their health seeking behaviours, qualitative data revealed some of their health actions. For instance, an IDI female participant aged 64 stated:

> *Who will go to them at the Hospital? They won't attend to us, all they need is your money and if you don't have the money, forget it. So I take herbs or use a particular chewing stick called "orin-agba" once I notice that my body is giving me some sick signals.*

Another IDI male participant aged 69 also collaborated the above. He said that:

> *I not only use what it is given from the healing center but I also treat myself by taking 'agunmu' in pap and 'aseje'. And if the health problem is life-threatening, we appease the god of good health through special preparations as sacrifices 'ebo' which will be taken to T-junctions of the road with the help of the herbalists or diviner*
>
> (IDI, 2007)

Table 4.6.7 presents the percentage distributions of the general patterns of health seeking behaviour by selected socio-demographic characteristics among the respondents. This is to show the influence of some socioeconomic variables on their health seeking behaviour.

Table 4.6.7 Percentage distributions of health seeking behaviour by Selected Socio-demographic variables

Variables	Hospitals /Clinics	Traditional Healers / Herbalists	Medicine Stores / Chemists	Spiritual / Religious Healers	Self Treatment	Total
Marital Status						
Married	13 (4.3)	19 (6.3)	42 (14.0)	57 (19.0)	168 (56.1)	299
Widowed	4 (1.9)	12 (4.8)	24 (10.1)	68 (30.4)	118 (52.6)	226
Literacy Status						
Literate	22 (10.3)	16 (7.5)	31 (14.5)	54 (25.3)	121 (56.8)	213
Non-literate	4 (1.2)	10 (3.2)	40 (12.8)	71 (22.7)	187 (59.9)	312

Source: Primary Data, 2007

Results in the Table 4.6.7 revealed that those who are married (56.1%) and widowed (52.6%) utilized self treatment first and foremost before the other available healthcare options. Similar pattern is observed in the educational status side of the table. Irrespective of their literacy status, the respondents reported self treatment as the first aid/form of health treatment, followed by others such spiritual/faith healers, medicine drug stores/chemists, traditional healers/herbalists and hospitals/clinics. The only exception is that the educated respondents (10.3%) reportedly utilized hospitals/clinics in the study area.

Table 4.6.8 depicts the perceptions of health status of the elderly with a view of examining their overall health wellbeing.

Table 4.6.8: Percentage distribution of self-rating of perceived health status among the elderly in Iwo community

Perceived Rating	Male	Female	Total
Excellent	81 (43.0)	103 (30.5)	184 (35.1)
Fair	127 (67.5)	172 (51.0)	299 (56.9)
Poor	16 (8.5)	26 (7.7)	42 (8.0)

Source: Primary Data, 2007

Table 4.6.8 reveals that the highest number of the respondents (56.9%) perceived their health condition to be *fair*, while 35.1% of them assessed theirs as *excellent* only. Forty-two respondents (8.0%) rated their health status as being *poor*. In relation to the elderly's perceptions of their state of health, they generally believed that they have sound health status. Those who considered themselves healthy used such phrases as *"Eegun eran nikan ni isoro agba"*, meaning that cracking the bone is the only problem of the toothless elderly. While those who considered themselves as having poor health status held the view that they were neglected by those who should have taken care of them, especially their adult children.

The term 'activities of daily living' (ADLs) refers to a basic set of everyday activities or tasks that an individual should be able to perform in order to live independently. They are not a measure of health status but of functional capabilities of an

individual. In other words, adults' activities of daily living (ADLs) are an important index to assess the physical function of elderly people.

Table 4.6.9 presents the independence levels in physical activities of daily living (ADLs)

Table 4.6.9: Percentage distribution of Independence levels in physical ADLs

% of the respondents, by level of Independence			
Activity	**Without Difficulty**	**Some difficulty**	**Needs Assistance**
Bathing	54.6	18.5	33.5
Dressing	62.5	22.3	15.2
Eating/Feeding	60.2	23.9	15.9
Getting up from bed	48.8	22.5	28.7
Moving in/outdoors	50.2	20.3	29.5

Source: Primary Data, 2007

In light of their health problems, Tables 4.6.8 and 4.6.9 imply that majority of the respondents were independent and active in performing activities of daily living (ADL) and still have the capacity to continue to work, especially among the male respondents, in informal settings as well as in non-pensionable jobs in old age.

Table 4.6.10 reveals the percentage distribution of activities of daily living (ADLs) by age and gender.

Table 4.6.10: Percentage distributions of ADLs by age and gender

	Total	**Limitations in ADLs[a]**	
Age	***N***	**Yes**	**No**
75 and older	71	79.2	29.5
70 – 74	115	58.8	41.2
65 – 69	153	52.6	47.4
60 – 64	186	33.2	66.8
Sex/Gender			
Men	188	35.8	64.2
Women	337	71.5	29.5
Total	525	100.0	100.0

Source: Primary Data, 2007

[a] Activities of daily living (ADLs) include needing the help of other persons with bathing or showering, dressing, getting in or out of bed or chairs, using the toilet, including getting to the toilet and getting around the house.

Table 4.6.10 indicates that old age (75+) and female gender are related with greater number of ADL limitations. The higher the age one attains, the higher the tendency to having increasing ADL limitations. In terms of gender, women (71.5%) appear to have more ADL limitations than men (35.8%). Those in the 60-64 age group reported less number of ADL limitations, compared to other older age groups. This implies that these respondents (66.8%) are still more active performing activities of daily living unlike other age groups. This is supported by the available census estimates for Nigeria which shows that 66.0% of the elderly aged 60 and older, continues to be in the labour force (NPC, 2004).

4.4.2 Indigenous Health Practices among the Elderly in Iwo Community

On the question of how the elderly traditionally positively influence their wellbeing (health status), the study revealed that a majority of the respondents use herbal medicines such as taking herbs, concoctions, for example *agunje, agunmu and aseje* to promote their well being, while a few respondents believed in orthodox medicine to restore their health, especially the literate ones. Education and modernization could be responsible for disbelief in herbal medicine. ***Agunje*** is a special preparation to be pounded before consumption following the prescription of a traditionalist, while ***agunmu*** is also the same type of preparation but will be taken in form of a drink *and* ***aseje*** is to be cooked before consumption.

Similarly, it is observed that certain body incisions and marks, among others, were made on their bodies, especially the wrist, with a view of keeping themselves hale and hearty. They referred to it as "*gbere iwosan tabi gbere afunni lokun*". To buttress this point, an elderly IDI participant aged 70 remarked that:

> *On that question, I remember the last time I was sick and it was unnecessarily taking time, incisions were made on my both hands and legs by a native doctor...*
>
> (Elderly IDI male, 2007)

Another elderly male IDI participant aged 64 stated:

> *...anytime I notice some feelings of sickness or weakness in my body, I take my concoctions and even use the waistband because I still work as a gateman in one of the secondary schools here. I also do some farm work better whenever I take my native medicine.*
>
> (Elderly IDI male, 2007)

Further investigations also revealed the usage of *chewing stick, native rings and waist-bands* for their trado-medicare. This is however revealing and popular among those who still engage in energy-sapping work such as hunters, farmers, gardeners, gatemen and few who still sell at the market, especially those within the age range of 60 and 69 years. This is similar to the findings of Ekpenyong, Oyeneye and Peil (1987) which stated that for economic reasons, most elderly Nigerians do not retire from active work and retirement was found to be a feature of workers mainly in established industrial and government institutions.

4.5 POVERTY AND WELLBEING NEXUS AMONG THE ELDERLY IN IWO

Examining the intersection of poverty and health is critical to understanding the full impact of income inequality on the overall well-being of the people. Poverty is an important indicator of wellbeing. This section explores the relationship between poverty and wellbeing of the elderly through qualitative data. The study asked respondents on how poverty affects their health wellbeing. The following were identified:

4.5.1 Poor Nutrition

Poor nutrition was identified by the respondents as they hardly have enough to buy the needed food items and take care of themselves. The types of food taken by the elderly was part of the FGD session which revealed that many of them mostly eat carbohydrate concentrated food such as cassava food products and less of proteinous food. For example, according to an elderly FGD female participant aged 67:

> *It is good to eat nutritious food but there is no money, so it is mostly carbohydrate like garri, fufu, pap and bean cake that I take. And this I believe affect one's health status whether an individual is going to be strong or not, whether old and young, male or female.*
>
> (A female IDI respondent, Isale-oba area)

4.5.2 Diminishing physical ability and Mental Capabilities

The respondents also reported declining physical strength especially within the context of performing activities of daily living. With advancing age comes the diminishing physical ability and mental capabilities of the elderly. This is revealed in the age groups of the respondents along with their health status in this study. Those who are aged 70 years and

above reported more health conditions than other age groups. In other words, as they grew older their physical health wellbeing decreases. This is also coupled with the poor socioeconomic resources available at their disposal over their life course and limited provisions made by health systems for old age related diseases. To buttress this, some of them reported eroded ability to engage in activities of daily living and instrumental ADL and also reported poor impairment, including blindness.

For instance, a male FGD participant aged 66 years stated that:

> *I used to work 8 to 12 hours before on my farm but now because of my age and strength, I hardly stand up for 2-3 hours a day.*
>
> (A male FGD participant, 2007)

Another male IDI interviewee aged 69 years stated:

> *...since I have no one to cater for me, I work in the day as a farmer and in the night as a night-guard in one of the secondary schools around. I work round the clock for peanuts and this negatively is affecting my wellbeing and health status...*
>
> (IDI male, 2007)

4.6 TEST OF RESEARCH HYPOTHESES

Hypothesis 1: Poverty (income) and age of the respondents.

H_O: There is no significant relationship between income and age of the elderly in Iwo community

H_1: There is significant relationship between income and age of the elderly in Iwo community

Table 4.7.1 shows levels of the income of respondents by gender.

VARIABLES	MALE				FEMALE			
	Low	Middle	High	Total	Low	Middle	High	Total
Age (in years)								
75 and older	22(73.3)	7(23.3)	1(3.3)	**30**	32(78.0)	8(19.5)	1(2.4)	**41**
70 – 74	18(48.6)	17(45.9)	2(5.4)	**37**	60(76.9)	16(20.5)	2(2.5)	**78**
65 – 69	38(61.2)	21(33.8)	3(4.8)	**62**	84(92.3)	5(5.4)	2(2.1)	**91**
60 -64	31(52.5)	20(33.8)	8(13.5)	**59**	105(82.6)	18(14.1)	4(3.1)	**127**

Using the Spearman's ranking correlation from Table 4.7.1; it reveals that the income level with age of the elderly has a negatively high relationship. In other words, the constant increasing years of age affects the level of income among the elderly in that the level of income decreases with the advancing age of the respondents. For instance, those who are 75 years and older (73.3%) reported the highest level of low income, followed by those within the age bracket 70 - 74 years (46.8%) who reported same low income on the male side. This same pattern applies to the female respondents as well. Following the Spearman's ranking correlation statistic of -0.76 for the male and female respondents, the null hypothesis is rejected and by the same token, accepts the alternative hypothesis that there is significant relationship between poverty (income) and age factor of the elderly.

Hypothesis 2: Age of the respondents and their wellbeing (health problems).

H_0: There is no significant relationship between age and health problems among the elderly in Iwo community

H_1: There is significant relationship between age and health problems among the elderly in Iwo community

Table 4.7.2 shows the health problems of the respondents by age.

Age	*N*	**Health Symptoms**	**Sensory Impairments**	**Functional Limitations**	**Disability**
75 and older	71	97.1	60.5	91.5	38.0
70 – 74	115	95.6	56.5	54.8	21.7
65 – 69	153	67.9	39.2	34.6	14.4
60 – 64	186	48.9	21.5	26.3	10.2

From the Table 4.7.2, using the Spearman's ranking correlation, the test of the relationship between the age of the respondents and their wellbeing reveals a positively high relationship. In other words, the elderly with increasing age are more likely to have various health problems, which also significantly impinges on their living conditions. Among those who are aged 75 years and older, 97.1% reported health symptoms, 60.5% had sensory impairments, 91.5% had functional limitations and 38.0% had disabilities compared to those who are in the age bracket of 60 – 64 years. Following the Spearman's ranking correlation statistics of 1 for the health problems, the null hypothesis

is rejected and by the same token accepts the alternate hypothesis that there is a significant relationship age and health problems among the elderly.

Hypothesis 3: Gender/sex of the respondents and their wellbeing (health challenges).

H_O: There is no significant relationship between gender (sex) and health challenges among the elderly in Iwo community

H_1: There is significant relationship between gender (sex) and health challenges among the elderly in Iwo community

Table 4.7.3 shows the health problems of the respondents by gender.

Gender	Health Symptoms	Sensory Impairments	Functional Limitations	Disability	Total
Women	75.9	43.7	52.1	19.7	64.1
Men	62.4	32.2	28.5	14.2	35.8
Total	71.0	39.6	43.8	17.7	525

Table 4.7.3 shows that there is a statistical relationship between gender/sex of the respondents and their health problems. It indicates that women (75.9%) reported more health problems than the men (62.4%). The calculated test statistics, for instance, sensory impairments (χ^2) 29.02, df = 3, $P<0.05$, indicate that female respondents have more health challenges, which also affect their living conditions. Following the decision rule and the calculated test statistics, the null hypothesis is rejected and by the same token accepts the alternative hypothesis that there is a significant relationship between gender (sex) of the respondents and their wellbeing.

Hypothesis 4: Educational status of the respondents and their wellbeing.

H_O: There is no significant relationship between educational status of the respondents and wellbeing among the elderly in Iwo community

H_1: There is significant relationship between educational status of the respondents and wellbeing among the elderly in Iwo community

Table 4.7.4 shows the health problems by educational status of the respondents.

Educational Status	Health Symptoms	Sensory Impairments	Functional Limitations	Disability	Total
Literate	60.1	21.5	11.7	6.5	40.5
Non-literate	63.1	16.3	13.7	6.7	59.4

The importance of education in this respect lies in the fact that it is an important determinant of the healthy living conditions of the elderly. Hence, the impact of education on wellbeing of the elderly cannot be overemphasized. Table 4.7.4 shows the relationship between the literacy status and wellbeing of the elderly. The percentage distribution of findings reveals significant differences in the level of health challenges of literate and non-literate respondents. The non-literate respondents reported more health problems than the literate ones. The chi-square tests also show a significant relationship between the two variables. Following the decision rule and the calculated test statistics, for instance health problems ($\aleph^2$) 33.45, df=3, $P<0.05$, the null hypothesis is rejected and by the same token accepts the alternative hypothesis that there is significant relationship between educational status of the elderly and their wellbeing in Iwo community. This also applies to the relationship between literacy and their health seeking behaviours.

Hypothesis 5: Marital status and health seeking behaviours of the elderly.

H_O: There is no significant relationship between marital status of the respondents and their health seeking behaviours in Iwo community

H_1: There is significant relationship between marital status of the respondents and their health seeking behaviours in Iwo community

Table 4.7.5 shows the health seeking behaviours of the elderly by marital status.

Variables	Hospitals /Clinics	Traditional / Healers Herbalists	Medicine / Stores Chemists	Spiritual / Religious Healers	Self Treatment	Total
Marital Status						
Married	13 (4.3)	19 (6.3)	42 (14.0)	57 (19.0)	168 (56.1)	299
Widowed	4 (1.9)	12 (4.8)	24 (10.1)	68 (30.4)	118 (52.6)	226

Table 4.7.5 indicates that those who are married responded more to their health problems unlike those without spouses. For instance, among the married, 4.3% utilized more of the hospitals/clinics and 56.1% engaged in self treatment of any health problems before visiting the clinics. This is expected because the married elderly ones have the benefits of intimacy and company of at least two persons thereby making a better health choice than others, who do not intimately know each other's health history. Following the decision rule and the calculated test statistics of 28.57, the null hypothesis is rejected and by the same token accepts the alternative hypothesis that there is significant relationship between marital status of the respondents and their health seeking behaviours.

It can be surmised, from the foregoing, that poverty influences health status as well as health seeking behaviours of the elderly. Poverty predisposes them to more health problems. It also shows that socio-demographic and socio-economic variables such as age, income, education, marital status, health seeking behaviour and family size affect the respondents' access to wealth / wellbeing. For instance, those who are aged 60 – 64 years had better access to wealth (income) vis-à-vis wellbeing than those aged 70 years and older with low income. Those who are educated had better access to wealth/wellbeing than those without formal education. Also, those who are married had better wellbeing than the widowed, while those with more children reported better wellbeing than those with none or few numbers of children living with them.

4.7 MULTIVARIATE ANALYSIS

The primary objective of any social research is to make an inference out of the investigation to the parent (general) population. To achieve this, both descriptive and analytical procedures were used. The multivariate analysis employed logistic regression to determine the 'net' effect of the independent variables on the dependent variables. The choice of this analytical technique was informed by the need to carry out binary analysis using a more powerful technique and the need to take into account the fact that socioeconomic and sociodemographic variables (poverty and wellbeing) are usually interrelated (Isuigo-Abanihe, 1998). The dependent variables include health measures of the wellbeing of the elderly, which are health symptoms, sensory impairments, functional limitations, disability and health seeking behaviour. The odds ratios and coefficients are

derived from the logistic regression models and are interpreted in relation to theoretically determined reference category in each independent variable. A reference category (RC) is required for interpreting the variables used in this analysis. The chosen RC variables represent those respondents, who are more likely to report wellbeing and RC variables are used for better comparison with other variables.

Table 4.7.6 below presents the odd ratios of two logistic regression models examining the influence of some selected socioeconomic and socio-demographic characteristics on the likelihood of reporting the overall wellbeing among the elderly in Iwo community. In this regard, separate models are developed on the basis of gender. The variable is coded 1 for those prone to better wellbeing and 0 if otherwise.

Table 4.7.6: LOGISTIC REGRESSION MODEL SHOWING THE EFFECTS OF SELECTED VARIABLES ON THE WELLBEING OF THE ELDERLY IN IWO COMMUNITY

	MALE		FEMALE	
Age	Odds	Coefficients	Odds	Coefficients
60 – 64	1.26*	0.317	1.38*	0.414
65 – 69	0.72	-0.401	0.87	-0.521
70 and older	1.00	RC	1.00	RC
Marital Status				
Married	1.17*	0.513	1.42*	0.528
Widowed	0.53	-0.332	0.86	-0.451
Separated/Divorced	1.00	RC	1.00	RC
Educational status				
No formal education	0.46	-0.452	0.68	-0.342
Primary education	1.00	RC	1.00	RC
Secondary education	1.39*	0.514	1.27*	0.560
Income level				
Below ₦1000	0.55	-0.349	0.62	-0.542
Between N1001-N5000	1.00	RC	1.00	RC
Between N5001 and above	1.29*	0.492	1.47*	0.386
Family Size/No of Children				
1 – 2 children	0.56	-0.461	0.75	-0.453
3 – 5 children	1.00	RC	1.00	RC
6 and above	1.25*	0.329	1.43*	0.471
Health Care Options Utilized				
Hospital/Clinics	1.21*	0.424	1.24*	0.502
Traditional Healers/Herbalists	0.64	-0.593	0.79	0.313
Drug Stores/Chemists	0.82	-0.412	0.65	-0.465
Spiritual/Religious/ Faith Healers	1.00	RC	1.00	RC
Self Treatment	1.13*	0.521	1.18*	0.411

Note: *P < 0.05, **P < 0.01; RC stands for Reference Category; Low income = [below N1000], Middle income = [between N1000-N5000], High income = [above N5000]

The odds ratios indicate that age of the respondents, marital status, educational status, income, family size and health seeking behaviour are significantly related to the overall wellbeing or healthy living conditions of the elderly. In the male model, men in the age bracket of 60 – 64 years are 1.26 times more likely to and those who are aged 65 - 69 years are 72 percent less likely to report better wellbeing than those who are 70 years and older, who formed the reference category (RC). The female model shows that those in age bracket of 60 – 64 are 1.38 times more likely to and those aged 65 -69 years are 87 percent less likely to report wellbeing than those in the reference category of age bracket of 70years and older. This result complements the results which reveal that female respondents are more vulnerable to health problems than male respondents. This probably is expected as a result of their biological anatomy and pressure of household chores. As observed earlier in this study, the older they become, irrespective of gender, the more health challenges they are likely to experience.

With respect to marital status, the regression model shows that married male respondents are 1.17 times more likely to and those who are widowed are 53 percent less likely to report wellbeing than those who are separated /divorced, who formed the reference category (RC). Similarly in the female model, those who are married are 1.42 times more likely to and those who are widowed are 86 percent less likely to experience wellbeing than those who are separated /divorced in the RC. This result also corroborates the finding which reveals that the married respondents have more resources and support network to cater for their needs than those without spouses or partners. This is also the supported by Self Management Ability (SMA) adopted in the theoretical framework for this study.

Educational attainment is an important factor that strongly influences access to wealth and wellbeing of the people in any given society. The regression model shows that men who had no formal education are 46 percent less likely to and those with secondary education are 1.39 times more likely to report better wellbeing than those with primary education (RC). In the same vein, the female model shows that those who had no formal education are 68 percent less likely to and those with secondary education are 1.27 times more likely to report wellbeing than those with primary education. This result also

supports the findings which reveals that the more educated the elderly are, the more empowered they are to handle their health problems.

Furthermore, the model shows that income is central to the wellbeing of the elderly. Table 4.5.2 also shows that monthly incomes strongly relates to the health status of the respondents. In the male model, those with low income are 55 percent less more likely to and those with high incomes are 1.29 times more likely to report wellbeing than those with middle monthly incomes in the reference category. While the female model shows the same trend; those with low incomes are 62 percent less likely to and those with high income are 1.47 times more likely to report wellbeing than those with middle incomes in the reference category (RC). This result confirms the finding which reveals that majority of the respondents is poor because they earn low monthly incomes which is less than N1000 monthly.

Family size or household composition is also a good factor to consider in respect to access to wealth or wellbeing of the respondents. The logistic regression model shows that, in the male model, those with 1 – 2 children are 56 percent less likely to and those with six or more children are 1.25 times more likely to report wellbeing than those with 3 – 5 children (RC). In the female model, those with 1 – 2 children are 75 percent less likely to and those with six or more children are 1.43 times more likely to report wellbeing than those with 3 – 5 children. This implies that the higher the number of children in the household, the better the wellbeing of the elderly in this study population.

On the health seeking behaviour, the logistic regression model shows that men who utilized hospitals or clinics are 1.21 times more likely to, as well as those who engaged in self treatment are 1.13 times more likely to experience better wellbeing than those who utilized the services of spiritual /religious healers, who formed the RC. Those who patronized chemists /drug stores are 82 percent less likely to, as well as those who consulted the herbalists are 64 percent less likely to report wellbeing than those who formed the reference category. In the female model, those who utilized hospital or clinics are 1.28 times more likely to, as well as those who engaged in self treatment are 1.18 times more likely to experience better wellbeing than those in the reference category (RC). Those who consulted traditional healers are 79 percent less likely to, and those

who patronized chemists /drug stores are 65 percent less likely to report wellbeing than those who formed the reference category.

4.8 DISCUSSION OF FINDINGS

The study utilized both quantitative and qualitative research methods, which created adequate insights on the objectives of the study. Based on the specific objectives outlined in Chapter One and data analysis presented, the study made substantial findings furthering the frontiers of knowledge on the wellbeing of the elderly.

The elderly generally hold differential perceptions of the concept of poverty. Some of these viewpoints are descriptive of the signs or characteristics of poverty. It is appropriate for intervention program to utilize these concepts in communicating with the people about poverty as well as health status. This signifies that there could be many related concepts in the description and definitions of poverty. This conforms to the findings of the other studies (HelpAge Int'l, 2002; WHO 2001; UN, 1999). Again, this also implies that the socio-demographic context in terms of age, gender, education, religion, traditional beliefs, and socioeconomic status constitutes on important link, which explains various predispositions, conceptions, perception and dimensions of poverty and health behavior. This idea of local understanding is very central (HelpAge Int'l, 2002; WHO, 2001). These variables or otherwise could help in assessing people's perception and how to make social/behavioral interventions in order to enhance appropriate understanding.

The study found that there is high level of poverty among the elderly. Majority of the respondents (74.2%) reported very low level of income because they realized or earned less than N1000 monthly using the income measure on one hand. Poverty is glaring on the faces of majority of Nigerians. Other visible signs of poverty can be traced to the rising unemployment, even worsened by the recent mass sack in the banking sector in the midst of the ongoing banking reforms. Since the second quarter of last year (2009), manufacturing companies that normally have the capacity to engage in massive employment had to close shops because of electricity and energy crises that have lingered even till now. Other studies (Gasparini *et al* 2007; Ramashala, M, 2000; Bose, A.B, 1994) in Nigeria also revealed similar finding.

On the other hand, the elderly possessed little or no assets or resources to make ends meet. For instance, about 5.8% (males) and 1.1% (females) had landed property as only possession. There is a clear relationship between number of assets owned and wealth quintiles. The respondents who scored low on the wealth index are those that live in households that own none or few assets. This approach conforms to the Human Development Index (HDI) by the United Nations (UN) to give a better evaluation of the level of poverty by looking beyond GDP figures. It is an index used to rank countries by level of "human development", which usually also implies whether a country is developed, developing or under-developing. The HDI combines three dimensions namely life expectancy, knowledge and education, and standard of living. A similar report by WHO (2003) reported a decline in the life expectancy in the country with 45.0 years for males and 46.8 years for females. By and large, Iwo town is a low income community with little or no industrial and economic activities, which must have impacted on their socioeconomic and health status of the elderly.

Furthermore, there are also differential perceived causes of poverty among the respondents. It was observed that there are certain factors that could expose the elderly to poverty in the study area. There is lack of farmland that could provide income/revenue opportunity for the elderly. This conforms to the finding of Eboyehi, F.A (2008) that land is a major asset which could be used to access loans. Lack of children's care and emigration of young family members, among others, did spread poverty among the respondents. The pressing economic crisis in terms of unemployment often leads to young family members searching for employment opportunities, forgetting the elderly. This is in line with the finding of Wahab, E.A (2005) where lack of children's support is articulated in favour of the economic wellbeing of the elderly.

The study also unveiled that the elderly reported more of health symptoms than sensory impairments, functional limitations and disabilities. These are four major domains of health according to WHO. Ageing is strongly related to health deterioration. Other things being the same, the health of the elderly is expected to decline with their increasing age (Barrientos, *et al* 2003). Joint pain (52.9%), fever (52%) and headaches (38.8%) are the

most leading health problems confronting the respondents in this study. A closer look reveals that elderly females reported more health symptoms than their males. This is similar to the findings of (Barrientos, A, 2002; Bengtson and Allen, 1993).

It is observed that socio-demographic context also influences the health status of the respondents. Such factors as education, employment status and age could play important role in shaping the health actions. Education (knowledge) and socioeconomic status could help individuals in selecting health pathways to follow but this does not translate to usage. Health behavior is usually implemented when individuals perceive its efficacy and are adequately motivated to take action to avert the occurrence of ill-health or treat ill-health. In other words, socioeconomic status has great influence on health seeking behavior. It also affects access to basic information and individual's health actions (Bakare *et al*, 2004; Bortz , W.M, 2002). In this study, for instance, respondents with low level of income and less formal education reported more health symptoms than those who are literate with middle and high income.

4.9 THEORETICAL IMPLICATIONS

The study is structured within Structuration and Successful Self-Management Ability of Ageing (SSMA) as theoretical stance. The essence of this section is to discuss some of the theoretical implications of the findings on the wellbeing of the elderly. The combination of Structuration and SSMA theories in this study provides a robust direction in assessing the socioeconomic and health status of the respondents. Structuration theory identified the significance of the interplay between human agency and social structure in order to understand and explain social reality. Hence, it implies that old age is socially constructed which varies from one society to another, following the social relations of the interacting human agents creating and re-creating social reality. The elderly and the children engage in intergenerational relations. It is theoretically argued in this study that the elderly with little or nothing to save or invest early enough are indirectly creating poverty for themselves because they will have little or nothing to reap except poverty, which will later become unacknowledged conditions of their material deprivations, which will impinge on their health status by extension.

Perception is central to health behaviour as revealed in this study. It influences the health action taken by the elderly in relation to their wellbeing. In other words, perception constitutes the stance from which cultural or social explanatory models of health and illness departs. The study showed that the respondents preferred home as the first hospital and as such, they engaged in home management of elderly health condition before going to the official health facility. The theoretical implication is that there is need to enhance moderate and accurate understanding of their socioeconomic and health status. There may also be a need to introduce community health workers in getting health services close to the home, rather than for them to be consulting non-biomedical channels.

SSMA theory postulated that to age gracefully and successfully is important to everyone (Kahn, 2002) and as such, it requires both direct resources and adaptive resources (self-management abilities). Direct resources include hobbies to realize stimulation or a close friend to realize affection while self-management abilities are resources central to ageing with high wellbeing because they are needed to gain and sustain wellbeing in later life. The theoretical implication of SSMA theory is directed towards realization of the six goals of wellbeing; which results to successful self-management of ageing. The systematic direction of the abilities to the dimensions of wellbeing makes it possible to derive concrete guidelines on how to improve successful ageing. Put differently, these abilities are meant to be developed long before the onset of old age either on individual or institutional basis. The self-management abilities are interdependent and often mutually reinforcing. For instance, having a positive frame of mind might lead to investment in resources and investment in resources might in turn lead to a variety of resources. Hence, the self-management abilities contribute jointly to sustainable wellbeing in later life and also constitute the overall concept of successful wellbeing. The study revealed that respondents possessed little or no resources to make ends meet. For instance, very few had landed property and majority earned less N1000 monthly. For this reason, they had low self-management ability which also signified low socioeconomic and health status of the elderly in the study area.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 SUMMARY

This study was carried out to investigate the challenges of poverty on wellbeing among the elderly in Iwo town. It also examined the extent of and interpretations of poverty among them as well as documented the health challenges facing the elderly in the study area. Furthermore, the study investigated the factors affecting their health and health treatment seeking behaviour.

The thesis is divided into five chapters. The first chapter describes the background information relating to the study and study participants. Chapter two deals with literature review, theoretical perspectives and conceptual framework. Chapter three describes the methodology of the study. Chapter four presents the study findings, analysis as well as discussions while chapter five talks of the summary, conclusions and recommendations of the investigation.

The study population is from Iwo, Osun State, a Yoruba community in Southwestern Nigeria. The study targeted men and women of Iwo origin aged 60 years and above. Information for the study was obtained through three sources namely the survey (questionnaire) method, focus group discussions (FGDs) and in-depth interviews (IDIs). The unit of analysis is the elderly individual. The data examined gender, social, cultural, economic, health and demographic factors. These factors are important for understanding the living condition of the elderly. Results from the qualitative data are also used to supplement and explain findings of the survey.

The analysis involves univariate, bivariate and multivariate. The univariate analysis uses frequency distribution and simple descriptive statistics to examine the distribution of respondents according to sociocultural, demographic and economic characteristics. At the bivariate level, there is a simultaneous examination of two variables using cross tabulations and chi-square test statistics. Multivariate analysis is used to determine the net effect of the independent variable on the dependent variable and

testing of the hypotheses. At this level, logistic regression analysis was employed to show the effect of socio-economic and demographic variables on the dependent variable.

Islam is the dominant religion in the study area, followed by Christianity with few followers of traditional religion. Majority of the respondents are given to the norm of polygynous marital union. Expectedly the level of educational attainment among the study population is significantly low in terms of western education. This precludes those trained in Quaranic education. The implication is that the elderly are mostly influenced by traditional values such as high fertility noticeable in the study population.

5.1 SUMMARY OF MAJOR FINDINGS

This section provides the summarised findings of the study. This will be based on the objectives of the study as outlined in chapter one.

The major findings of the study are:

1. There is high level of poverty among the elderly in the study population using both income and non-income indicators. The majority of the respondents reported very low level of income because they realised or earned less than N1000 monthly with little or no assets or resources to make ends meet. This further confirmed that Iwo is a low income community with little or no industrial and economic activities.
2. There are also various perceptions given to the concept of poverty among the elderly. This can be grouped into five categories namely *ise* (deprivation), *aini* (want or lack), *osi* (wretchedness), *iya* (suffering or hardship) and *aibegbejo* (inequality). This may be adduced to the community characteristics such as history, culture and language of the respondents in Iwo, which influenced their health seeking behaviour.
3. There are differential perceived determinants of poverty in old age among the elderly. These are lack of farmland, lack of child care and support, emigration of young family members and problem of illiteracy among others as factors spreading poverty amongst them.

4. Majority of the elderly respondents reported more health symptoms/problems than sensory impairments, functional limitations and disabilities, which are the four major domains of health. Gender-based differential analysis revealed that elderly females reported more health challenges than their elderly male counterparts. Self-treatment is popular among majority of the elderly with more of home-based herbal remedy and less usage of modern drugs at the household level. The respondents utilized various self and local health remedies such as local herbs (*agbo* and *agunmu*), creams (*aboliki* and *rub*) and other preparations before they seek medical help from official health sector.
5. There is strong association between poverty and health wellbeing among the elderly in the study area. Those elderly with low level of income and less formal education reported more health challenges than those who are literate with middle and high income.

5.2 CONCLUSION

The findings of the study confirm that there is high level of poverty (economic/wealth inequality) among the study population and as such the elderly are deprived of assets or resources to make ends meet. Put differently, their socioeconomic well being is poor in this population group. Consequently this impacted on their health status, thereby affecting their activities of daily living. The elderly suffered both economically and otherwise because there is no comprehensive and adequate social security in Nigeria.

The study also concluded that differential perceptions of poverty impinged on their health status and health seeking behaviour. Self treatment or home remedy is the first clinic as they perceived and defined health conditions and behaved accordingly. There was generally low utilization of the primary and secondary health care infrastructures because there is only one General Hospital in the study area.

The study also concluded from the data generated that lack of children care and support, landlessness, lack of income-generating assets and rural-urban migration of young family members are some of the perceived factors that contributed to poverty in old age among the respondents.

Furthermore, from the gender-based differential analysis, it is concluded that the females reported more health challenges than their male counterparts, with joint body pains (arthritis), headache and fever as the most common leading health problems facing the respondents in the study area.

The study also concluded by offering a novel explanatory model for old age dimension of poverty in a semi-urban place such as Iwo community using both income and non-income measures of poverty. It also sheds light on the perceived factors that predispose the elderly to poverty. These include landlessness (farmland), lack of income-generating assets and lack of children care and support among others.

It is as well confirmed by empirical evidence that the problem of poverty impacted on the health status, health seeking behaviour as well as socioeconomic wellbeing of the elderly people in Iwo town. Hence, this provided the basis for establishing the failure of the Nigerian State in fulfilling its social contract to the elderly. As a result, the study clearly supports, in light of the findings, the importance of home-based management of old age related ill-health and informal social support systems, unlike other similar works that supported the westernized non-African Old People's Homes.

5.3 RECOMMENDATIONS

In light of the findings that emanated from the study, the following are recommended:

- There is need to provide monthly stipend to the elderly who spent most of their occupational life in agriculture, just like those formal sector retirees. This will boost their financial and economic capacity.
- Health management needs to be home-based since most of their ailments are treated at home fronts and house-to-house medical team can be of more help. And more medical attention should be given to the elderly females.
- Primary and secondary health care infrastructures should be established in the study area and health related training should be provided to community volunteers and community health workers.

- Elderly people should be actively involved in useful services and activities in the family and community levels that can promote their social and economic wellbeing for those still willing to contribute their quota.
- Government need to urgently provide specialized categories of manpower training to provide more satisfactory services to the elderly. Such training should include both geriatric doctors and nurses and community workers to deliver different types of services for the elderly.
- Government should provide good affordable health services for the elderly in Nigeria since health problem has been found to be one of the major challenges of the elderly.
- There is need to re-examine and revive African traditional systems and values to address the challenges of old age poverty and ill-health in the face of the global economic recession that undermine the social security worldwide.
- As much as possible, family members should be enlightened and encouraged not to abandon their elderly ones, but to love and care for them and provide for their basic needs. This act will attract the blessings of the elderly and probably not make them a total liability, for a healthy elderly will be more independent and capable to go about their daily business, which is also known as, activities of daily living.

5.4 POLICY IMPLICATIONS/RECOMMENDATIONS

In view of the contemporary and policy relevance of this thesis and the findings, policy makers in Nigeria should give more attention with strong political will to create a society for all ages according to the United Nations' and other International agencies' vision and mission.

The following policy recommendations based on the findings of this study need to be pursued:

- In light of the fact that the study population is characterised by low income and low industrial/economic profile, government at the different levels should create enabling environment for individual investors, corporate bodies and other relevant

non-governmental organisations to establish businesses to boost the economic activities, which will invariably lead to industrial development in this area. This will directly and indirectly impact the socioeconomic wellbeing of the elderly. By so doing, the children will be gainfully engaged and those who are still strong enough and willing to continue to work among the respondents will have the opportunity

- Given the high prevalence of health challenges among the elderly coupled with only one general hospital in the area, there is need for the establishment of more health care infrastructures especially primary and secondary healthcare centers and specialised health professionals such as geriatric doctors and nurses for the health needs of the elderly in Nigerian communities.
- Since home-based; self treatment appeared to be the first point of call among the elderly probably because of their traditional beliefs that illness is better treated with home-made herbal remedies, there is need for house-to-house health education and enlightenment efforts to scale up home-based health management capacity before accessing the official health infrastructures.
- Based on the trends and projections of the growing numbers of the elderly population and the attendant socio-demographic transformations due to urbanization and industrialization, there is need to create community-based support centers across the country to regularly take care of the elderly in their respective communities.
- Mass media attention should be focused on the elderly members with the view of developing appropriate measures to help them live a more healthy and rewarding life.
- Existing government programmes and policies of the elderly should be constantly updated and implemented to cover both formal and non-formal categories of the elderly, especially the elderly women.
- Government should put in place old age payment scheme that will ensure prompt and regular payment of monthly benefits and services to the elderly, thereby reducing the incidence and prevalence of poverty among them.

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Appendix 1: Data Collection Instrument1
Questionnaire

Dear Respondent:

Greetings. This is a research work on poverty and health among the elderly here in Iwo. It is a part of the requirements for the award of a Ph.D degree in the Department of Sociology, University of Ibadan, Ibadan. I would appreciate your cooperation by providing candid and correct responses to the questions. Whatever information you give will be used mainly for academic purposes and all your comments shall be treated with utmost confidentiality.
Do you consent to be interviewed?
If YES, the interview proceeds, if NO, the interview terminates at this point.
Thank you

General Information:

1. Identification Number:.....
2. Name of Interviewer..... Signature.....
3. Name of Supervisor..... Signature.....
4. Date of Interview.....:.....
5. Time interview commenced..... Time ended.....
6. Name of community:.....
7. Language of interview:.....

Section A: Socio-Demographic Characteristics

No	Questions /Variables	Coding Categories	Skip to
101	Respondent's sex	Male.....1 Female.....2	
102	Marital Status	Single.....1 Married.....2 Widowed.....3 Divorced.....4 Separated.....5	
103	Age as at last birthday	Completed years	
104	Have you ever attended school?	Yes.....1 → No .....2 →	105 106
105	What is your highest level of education?	No formal education.....1 Primary school (completed).....2 Primary school (not completed).....3 Secondary school (completed).....4 Secondary school (not completed).....5 Tertiary institution.....6 Bible / Koranic school 7	

106	What is your occupation?	Civil servant.....4 Trading .....2 Farming / hunting.....1 Artisan.....3 Others (specify).....5	
107	What is your employment status?	Self-employed.....1 Unpaid family worker.....2 Retired.....3 Unemployed.....4 Others (specify).....5	
108	What is your religion?	Christianity.....1 Islam.....2 African Traditional.....3 None.....4 Others (specify).....5	
109	Marriage Type:	Traditional.....1 Church/Mosque.....2 Court marriage.....3 Others (specify).....4	
110	Does your marriage type allow more than one wife?	Yes.....1 → No.....2	111
111	How many wives do you have?	2 wives.....1 3 wives.....2 more than 3 wives.....3	
112	How much do you earned from all sources (in naira) monthly?	Income.....	

Section B: Poverty/Financial Status among the Elderly

201	How much is your daily spending on food and non-food items?	Between ₦10 - ₦140.....1 Between ₦141 – ₦200.....2 Between ₦201 – ₦500.....3 Above ₦500.....4 Others (specify).....5	
202	Who do you depend on for daily expenses?	Self.....1 Children.....2 Relations.....3 Friend(s).....4 Others (specify).....5	
203	How much is your monthly income?	Please state (in naira).....	
204	Is the monthly income regular?	Less than N1,000.....1 N1001 – N5,000.....2 N5001 - N10,000.....3	

205	What is/are the sources of your income?	Children's remittances.....1 Extended family members.....2 Pension/salaries.....3 Meeting/association/friends.....4 Farm sales.....5 Borrowing.....6 Thrift.....6 Begging/through charity.....7 Others (specify).....8	
206	Do you still work?	Yes.....1→ No.....2	207
207	What kinds of work do you engage in?	Please specify.....	
208	What do you do for a living?	Farming.....1 Trading.....2 Full time housewife.....3 Fishing.....4 None.....5 Others(specify).....6	
209	Are you a Pensioner?	Yes.....1→ No.....2	210
210	If Yes, how regular is your pension?	Yes.....1 No.....2	
211	Do you have any properties or assets?	Yes.....1→ No.....2	212
212	Indicate as many as possible you have..	Radio.....1 Television.....2 Jewelry.....3 Motorcycle.....4 Refrigerator.....5 Electric fan.....6 Car.....7 Telephone.....8 Land/House.....9 Savings.....10 Others (specify).....11	
213	Which of the following household items or properties do you have?	Radio.....1 Television.....2 Fridge.....3 Fan/air-condition.....4 Vehicle.....5 Land/house.....6 Others (specify).....7	

214	How many children have you given birth to?	1-2 children.....1 3-4 children.....2 5-6 children.....3 More than 6 children.....4 No child.....5	
215	How many of them are living with you now?	1.....1 2.....2 3.....3 4.....4 All of them.....5 None.....6	
216	Do you receive support from your adult children?	Yes.....1→ No.....2	217
217	If Yes, is their support regular?	Yes.....1 No.....2	
218	What help or support do they provide?	Payment of medicalbills.....1 Payment of rent/provision of housing.....2 Provision of money and food.....3 Washing of clothes.....4 Fuel/firewood collection.....5 Water collection.....6 Going to the market.....7 Others (specify).....8	
219	Do you belong to any association / society?	Yes.....1→ No.....2	220
220	What type of support do you receive from your adult children?	Material.....1 Non Material.....2 Both.....3 No Response.....4	
221	What type of society /association do you belong to?	Elder's association.....1 Cultural society.....2 Village association/meeting/thrift.....3 Religious.....4 Cooperative society.....5 Professional (e.g market women ass.)...6 Others (specify).....7	
222	Does the association you belong to provide any support?	Yes.....1→ No 2	223
223	What kind of support do they render?	Medical support.....1 Emotional support.....2 Financial support.....3 Moral support.....4 Physical support.....5 Domestic support.....6 Others (specify).....7	

224	What benefits do you derive for being a member of this group?	Financial benefit.....1 Members send their children to assist me.....2 Share of meat, food items & drinks.....3 Others (specify).....4	

Section C: Wellbeing/Health status among the Elderly

301	How many times do you usually eat per day?	Once.....1 Twice.....2 Three times.....3 More than three times 4	
302	Where do you get water from?	Tap.....1 Well water.....2 River/stream/pond.....3 Rain water.....4 Others (specify).....5	
303	How regularly do you fetch water for yourself?	Most often.....1 Sometimes.....2 Never.....3	
304	What physical activity do you do daily/weekly?	Please specify	
305	At your current place of residence, what type of toilet facility do you have?	Jewelry.....1 Pit toilet.....2 Bush.....3 Others (specify).....4	
306	Do you think the type of your toilet affect your health?	Positively.....1 Negatively.....2 Don't know.....3	
307	When last did you fall ill?	Last week.....1 Two weeks age.....2 Last month.....3 Two months age.....4 Don't know.....5	
308	Do you have any major health problem(s) in the last three months?	Yes.....1 No.....2	
309	How do you describe your health wellbeing?	Excellent.....1 Fair.....2 Poor.....3	

310	What are the major health problems common with you?	Arthritis (Joint Pain).....1 Headaches.....2 Fever.....3 Chest pain.....4 Poor sight.....5 Poor hearing.....6 Diarrhoea.....7 Cough.....8 Trembling Hands.....9 Decreased mobility.....10 Others (specify).....11	
311	Where do you go for treatment when you are ill?	Hospital /Clinics.....1 Traditional Healers / Herbalists.....2 Medicine Drug Stores / Chemists.....3 Spiritual / Religious / Faith Healers.....4 Self Treatment.....5	
312	Who pays for your treatment /medical bills?	Children.....1 Extended family members.....2 Friends.....3 Self 4	
313	What major problems do you encounter in getting treatment when you are ill?	Transportation.....1 Finance.....2 Others (specify).....3	
314	What factor(s) determine poverty among the elderly?	Please specify.....	
315	With whom are you living?	Spouse.....1 Alone.....2 Children.....3 Relative's child.....4 Others (specify).....5	
316	Do you have difficulty in hearing or seeing without aid?	Yes.....1 No.....2	
317	Do you have difficulty in doing any of the activities of daily living?	Yes.....1 No.....2	
318	Do you have disability or difficulty in bathing, dressing or getting up from bed?	Yes.....1 No.....2	

319	How often do your children living far away come home to see you?	Weekly.....1 Monthly.....2 Every others month.....3 Every six month.....4 Yearly.....5 Occasionally.....6 They don't come.....7 Others (specify).....8	
320	How often do you receive assistance from children living far away (city)?	Always .....1 Often.....2 Rarely.....3 They don't visit.....4	
321	Do your children who are not living with you always send items to you?	Yes .....1 → No.....2	322
322	What kind of items do they send?	Money.....1 Food.....2 Clothes.....3 Drugs.....4 Letters.....5 Others (specify).....6	
324	Do your children not living with you send someone to stay with you and look after you?	Yes.....1 → No.....2	325
325	Who is the person sent to you?	House help.....1 Wife.....2 Children.....3 Others (specify).....4	
326	What kind of care and support do these people render?	Water collection.....1 Fuel/firewood collection.....2 Washing of clothes.....3 Assist in going to the market.....4 Physical and emotional support.....5 No support.....6 Others (specify).....7	
327	How does poverty affect your wellbeing?	Please explain.....	
328	Do you visit your children?	Yes.....1 → No.....2→	329 330

329	How long do you normally stay with them?	Less than a month .....1 One month.....2 2 - 4 months.....3 More than 6 months .....4 One year .....5 Others (specify).....6	
330	Why don't you visit them?	They have no / stable job.....1 Life in the city is stressful.....2 No chance to visit them.....3 I have to take care of the house.....4 Nobody to visit.....5 Visiting them will not change the situation of things.....6 Others (specify).....7	
331	How do you interpret poverty in old age?	Please specify.....	
332	What do they do when you are in need or ill?	Send me to my children to look after me.....1 They take me to hospital.....2 They take me to city to take care of my ill health.....3 Others (specify).....4	
333	What effect does their absence have on you as an elderly person?	Poverty .....1 Loneliness.....2 Isolation.....3 Neglect.....4 Ill health.....5 Others (specify).....6	
334	What do you think can be done to solve the problems of the elderly in this community?	Provision of employment for our children.....1 Rural development.....2 Provision of old age security.....3 Provision of old people's home.....4 Others (specify).....5	

Appendix II: Data Collection Instrument2

Focus Group Discussion Guide

Greetings/Introductions. You are welcome to this discussion session. I will want everyone present here to participate actively in the discussion. I will like us to talk about issues that concern the elderly people in this community, specifically regarding their health and socio-economic status. This discussion will be tape-recorded to assist us remember whatever we talked about here. Hence I want you to feel free to express yourself.

Please let us talk about the following:

1. In this community, how do people perceive poverty? When talking about poverty, how is it perceived among different age groups (youth, adults and especially, the elderly)? (probe)
   How do you know/perceive a poor elderly person in this community? (probe)
2. How would you describe a healthy elderly person in this community? (probe)
   What situation or things in your opinion constitute a hazard to your health in this community? (probe)
3. What are the health problems among the elderly in this community? (probe)
   What are the perceived determinants of poverty in old age? (probe)
4. In what different ways do the elderly get treatment here? (probe)
   Who is responsible for the care and support of the elderly in this community?
   Is there any special program meant for the elderly in this community?(probe)
5. What types of problems do elderly ones, like you, encounter in accessing health care services in this community? (probe)
   Who takes care of treatment/medical bills? (probe)
6. Who among the elderly men or elderly women are more prone to poverty in this community? (probe)
   Who among the elderly men or elderly women are more prone to health problems in this community? (probe)
7. How does poverty influence the wellbeing of the elderly in this community?
   How does one's health relate to the socio-economic activities or wellbeing of the elderly people?
8. Do you think that your separation from your children as a result of migration influence your health? (probe)
9. What are the things do you think can be done through the household, community and government separately to improve the health status of the elderly people in this community? (probe)
10. Coping Strategies. What are your economic activities that bring income?
    How do you cope in carrying out the daily activities of living such as bathing, eating, walking, shopping among others with economic crisis? (probe)

In conclusion, the moderator summarises the key contributions made by participants and ask them: (a) does this summary represent all the views we have expressed today? (b) is there any anything we have to add? (c) what suggestions/advice do you have for us?

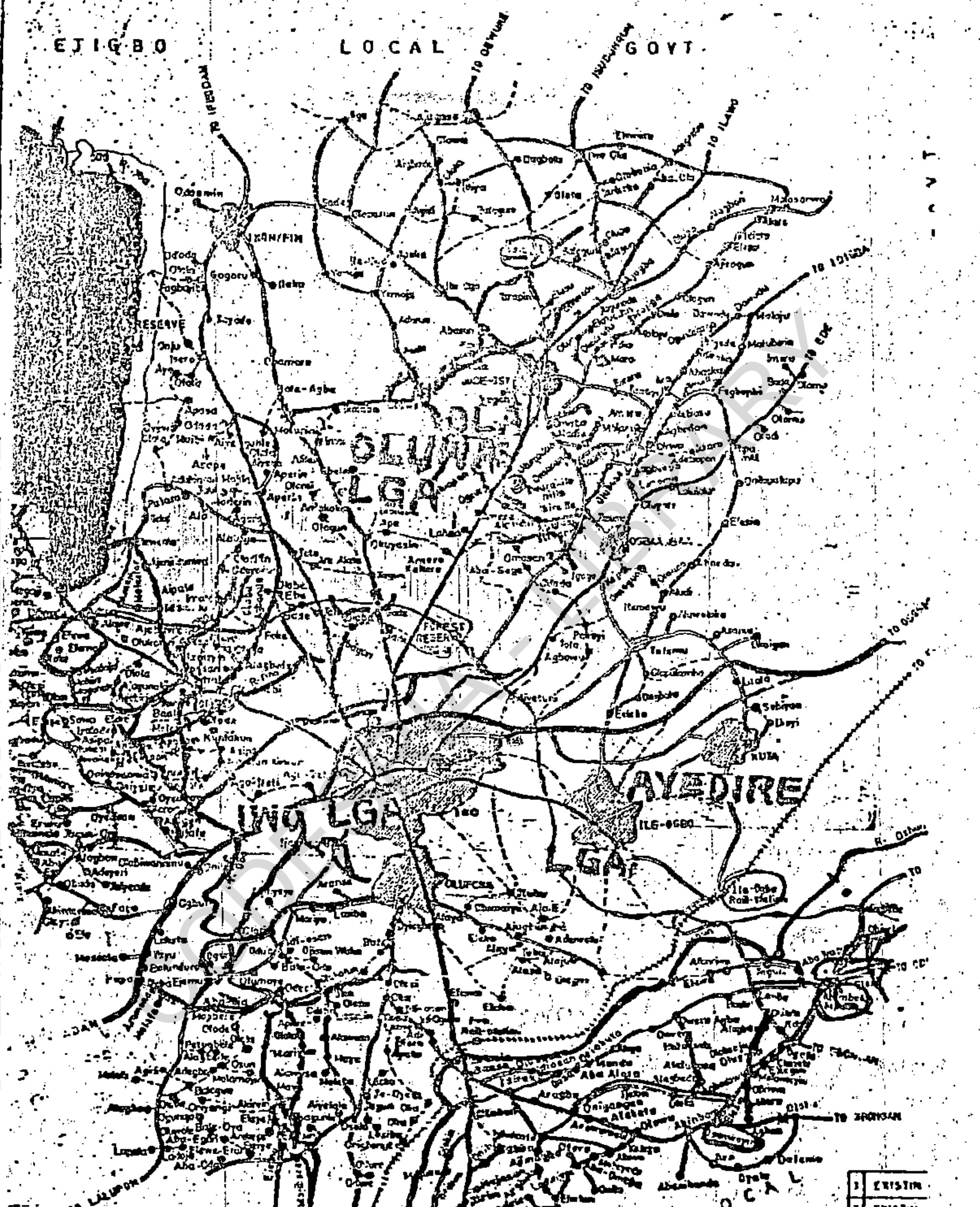
Appendix III: Data Collection Instrument3

In-Depth Interview Guide

Greetings. You are welcome to this discussion session. I will want everyone present here to participate actively in the discussion. I will like us to talk about issues that concern the elderly people in this community, specifically regarding their socio-economic and health status. The information from the interview will be used to improve the welfare of the elderly Your participation is very important but it is entirely voluntary.

Please let us talk about the following:

1. I want you to talk about yourself in terms of general socio-demographic characteristics such as the position/title occupied, educational status, religious affiliation and number of children among others.
2. How do people perceive poverty in old age here?(probe)
   How would you describe an elderly person, like you in this community? (probe). How do you know/perceive a poor elderly person in this community?
3. Socio-economic conditions of the elderly. Ask sources of income per month? (probe)
   Can you afford to meet your basic needs? (probe)
4. What are the determinants of poverty in old age? (probe)
5. What are the health problems among the elderly in this community? (probe)
   When indisposed, where do you go for care? (probe)
6. In what different ways do the elderly get treatment here? (probe)
   Who is responsible for the care and support of the elderly in this community?
   Is there any special program meant for the elderly in this community?(probe)
7. What types of problems do elderly ones, like you, encounter in accessing health care services in this community? (probe)
   Who takes care of treatment/medical bills? (probe)
8. Who among the elderly men or elderly women are more prone to poverty in this community? (probe)
   Who among the elderly men or elderly women are more prone to health problems in this community? (probe)
9. How does poverty influence the health of the elderly in this community?
   How does one's health relate to the socio-economic activities or wellbeing of the elderly people?
10. Do you think that your separation from your children as a result of migration influence your health? (probe)
11. What are the things do you think can be done through the household, community and government separately to improve the health status of the elderly people in this community? (probe)
12. Do you need some help in carrying out the daily activities of living such as bathing, eating, walking, shopping among others? (probe)



—MAP OF IWO LAND

Appendix V: An Elderly Resident of Iwo Town

Appendix VI: A Street showing their houses