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QUALITY OF LIFE AMONG THE ELDERLY IN A PERI-URBAN COMMUNITY IN IBADAN, NIGERIA

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Abstract

The elderly face a broad range of medical, physical, psychological and social needs that require assistance and supervision on a temporary or permanent basis. These needs and health challenges often vary from community to community due to a number of factors. However, such concerns among the elderly in a peri-urban setting, with a mixture of rural and urban characteristics, have not been fully investigated. This study was therefore designed to determine the perceived psycho-social needs, quality of life (QoL) *and health-related challenges experienced by the elderly in Apete, a peri-urban area in Ibadan.*

The study was cross-sectional and employed a two-stage sampling technique to select 600 consenting elderly from the 12 neighbourhood clusters and houses in the community. A semi-structured questionnaire used had questions on socio-demographic characteristics, perception, perceived needs, health-related challenges and typologies of social support received. These were measured using QoL (36); Depression (30); General Health-GH (33); and Dementia (8) scales. Scores of ≤15 and ≥15-36 on the QoL scale were categorized as high and low respectively. Depression scores of 0-9, >9-19 and >19-30 were classified as normal, mild and severe respectively. The GH scores of ≤15, >15-20 and >20-34 were categorized as lack of distress, moderate distress and severe distress respectively. Dementia scores were categorized as follows: 0-2 (intact functioning), 3-4 (mild impairment), 5-6 (moderate impairment) and 7-8 (severe impairment). Data were analysed using descriptive statistics, Chi-square test and logistic regression at p=0.05.

Age of respondents was 67.7±7.1 years; 56.2% were male; 78.1% were married; 28.7% had no formal education and 12.5% were living alone. Majority (86.2%) opined that home-based care was better for the elderly while most 90.1% had high QoL. Respondents' needs included inadequate financial support (78.8%) and poor access to regular medical check-up (64.8%). Respondents with mild and severe depression were 27.7% and 4.7% respectively while moderate and severe distresses were 12.2% and 3.2%. Few (9.3%) had mild dementia; moderate and severe dementias were 0.2% and 0.3% respectively. Other reported health problems included insomnia (40.5%), hypertension (36.0%), diabetes (28.3%) and stroke (20.0%). Insomnia was significantly higher in males (50.2%) than females (49.8%). Health workers' unfriendly behaviour (93.3%) was a major concern among respondents. Among the married, more males (44.6%) than females (22.7%) received social support from their spouses. Children (91.3%) constituted the respondents' main source of social support while support from the community was 15.5%. Significantly more females (93.9%) than males (89.3%) received social support from children. Respondents with formal education were more likely to have high QoL compared to those with informal education (OR: 2.5; CI: 1.2-5.0). Respondents living with other people were more likely to have high QoL compared to those living alone (OR: 2.2; CI: 1.2-4.0).

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Access to adequate social support and provision of patient-friendly health care services constituted the major needs of the elderly at Apete. There is need to re-orientate and re-train health workers on the issue that constitute QoL especially in the area of social support given to the elderly.
Keywords: elderly, quality of life, perceived psycho-social needs, social Support

1. Introduction

Globally, there is an increasing ageing population. In 1950, just over five percent of the world's population was 65 years or older. By 2006, that number had jumped to eight percent. By 2030, experts anticipate that older adults will comprise 13 percent of the total population; one in eight people will be 65 years old or older (Lopez, Mathers, Ezzati, Jamison & Murray, 2006). The greatest increase in the number of older people occurs in the developing and middle income countries which are now experiencing rapid shifts from high mortality and high fertility to much reduced fertility and greater longevity (Ekpeyong, 1995). While developing countries will experience the most rapid ageing, with an increase of up to 140 percent, they will experience an increase averaging 51 percent. Due to this, developing nations would increasingly face difficulties supporting their older population (World Health Organization, 2002).

In most of these countries, the elderly live at the bottom of the socio-economic strata. Ageing has become a global phenomenon and a critical policy issue yet to receive proper attention from the governments of developing countries including Nigeria (Abdulraheem and Parakoyi, 2005). Older women, in particular, face harsh conditions (Ajomale, 2007).

Meanwhile, the elderly have vital roles to play in the society. For instance, they often serve as agents of change, providing mentoring and social support to members of their families and communities (IMSERSO 2004). Older persons face many challenges which make them vulnerable to many health and social problems. Some enjoy no proper pension system and have scarce retirement savings, if any (Global Action on Aging [GAA], 2005). In 2000 the number of people aged 60 years and above globally stood at 606 million. It is estimated that by 2050 this figure is expected to reach 2 billion (Aboderin, 2006). According to the 1991 census report, the elderly constituted 5.2% of the total population of 88.5 million Nigerians and the number is expected to be 10 million by the year 2020 (Osi-ogbu, 2011). In the report of National Population Census (NPC) of 2006 (NPC, 2006), Nigeria had a population of 140.8 million people, making it the most populated nation in Africa and the

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ninth in the world (United Nations, 2005). The population growth rate of the year 2000 to 2005 is 2.5% with 5% of the total population aged 60 years and above (Abiodun, Adekeye and Aruonagbe; 2011).

There is a major change in the age structure of the Nigerian society. The National Population Commission confirmed an increase in the percentage and the number of those aged 60 and above National Population Commission, 2006. In the coming years, the ageing population is expected to increase in number, and life expectancy rates will gradually increase with significant social and economic implications to the individuals and the Nigerian government (National Population Commission, 2006).

The United Nations has set aside September 29th of every year as the International Day of the Elderly in recognition of the ageing population, and to appreciate them as an integral part of society. During the 2011 celebration of the International Day of Older Persons which took place in Abuja, the Vanguard Newspaper edition of Thursday 29th September, 2011 reported the Minister of Women Affairs and Social Development, Hajia Zainab Maina, to have stated that the Federal Government had reached an advanced stage of plans to evolve a National Policy on Ageing which would be aimed at bringing issues of the elderly people into the mainstream national development agenda, serving as an instrument for improving the QoL of older citizens in Nigeria (Vanguard Newspaper, 2011). Despite the celebration, the care and QoL of our elderly is still a major societal challenge.

Poverty and high cost of living is pushing the elderly to the roads as destitute (Fajemulehin, Ayandiran & Salami; 2007). Before "modernization" came to "destroy" the concept of the extended family system and replace it with the nuclear family, the extended family as a social structural system served more or less as a form of social insurance (traditional safety net) for old age (Osemeka, 2010). The family in Nigeria used to include members of the extended lineage: parents, children, brothers, sisters, grandparents, grandchildren, aunts, uncles, cousins, nephews and nieces. There is an observable progressive shift in the conventional responsibilities away from the family. Traditional functions of the family like care and social support to older family members have gradually decreased in the recent past due to economic problems, migration and influence of foreign culture (Ajomale, 2007).

Hence, the problem is that the elderly in Nigeria face a broad range of medical, physical, psychological and social needs that require assistance and supervision on a temporary or full-time basis. Knowing what their

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perceived health challenges and needs are will help in determining appropriate intervention for them (Boehlke, 2010). This study investigates the QoL among the elderly in a peri-urban community in Ibadan, Nigeria.

Meanwhile, the perceived needs, QoL, health-related challenges and type of social support among the elderly as well as the factors which influence their care especially in emerging peri-urban settings such as Apete are yet to be fully known. Findings from this study are potentially useful for providing information relating to the status of care provided to the elderly in peri-urban communities. In addition, the findings may have useful implications for evidence-based policy formulation and design of health promotion and education, and strategic framework for the care of the elderly in peri-urban settings.

2. Methodology

2.1. Study Setting

Apete, a peri-urban community, is located within Ido Local Government Area (LGA) of Oyo State. The community's geographical coordinates are latitude 7.4491667l and longitude 3.8722222l (travelingluckafrica, 2012). It is about 26.6 km away from Sango, Ibadan. It is a multi-ethnic community, although the Yorubas constitute the predominant ethnic group. The major occupations of the people are trading, transportation and craft. A sizeable population are civil servants in local, state and federal establishments while some are retirees. The community has access to electricity supply but lacks pipe-borne water. There is only one public clinic in the community, seven private health care providers and several patent medicine vendors. Other social facilities in the community include one primary school, one police station and a motor park for commercial drivers. There are no special services for the elderly. Commercial minibuses and motorcycles serve as means of internal transportation. The most common means of transportation in the community are by motorcycle (locally called *okada*), taxi cabs and buses. Most roads in the community are yet to be tarred.

The study population constituted of retired and in-service elderly people aged 60 years and above residing in Apete community. The respondents consisted of men and women. They were permanent residents of Apete during the period of the study.

The study followed basic ethical principles guiding research involving human participants. Ethical approval was obtained from Oyo State Research Ethics Review Committee. Adequate information regarding the study was given to the respondents and informed consent was obtained from the respondents before they were

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interviewed. Respondents were assured of the confidentiality of their responses during and after data collection. They were informed that information obtained from them would be used for research purposes only. Respondents were told that participation in the survey was voluntary, and that they could withdraw at any time if they so wished without any penalties or loss of privileges. Each respondent was assured that participation in the study was voluntary and that information disclosed by the respondents would be kept confidential. They were also told that their names were not required on the questionnaire. Respondents were encouraged to ask questions on what they did not understand in the questionnaire. Explanations were given to respondents as required to aid their understanding of unfamiliar terms.

2.2. Recruitment Procedure

To obtain a sample of the population for the study, a multi-stage sampling approach was employed. Cluster, proportion and purposive sampling techniques were adopted for this purpose. This was to give each member of the target population equal opportunity of being selected for the study. The procedure involved two steps (stages) as follows:

In order to obtain a representative sample of the population for the study, a multi-stage sampling approach was employed. Cluster, proportion and purposive sampling techniques were adopted for this purpose. This was to give each member of the target population equal opportunity of being selected for the study. The procedure involved two steps (stages) as follows:

(1) The community was geographically divided into twelve clusters or neighbourhoods. The respondents interviewed at the study area were selected from each cluster by dividing the sample size by the number of clusters. This was because the total population of the elderly within the 12 clusters could not be assessed. Fifty respondents were interviewed per each cluster (This implies 600 respondents interviewed at all the 12 cluster areas).

(2) Purposive sampling was then used in the selection of eligible respondents at the household level from each cluster area. Any available eligible respondent in a household during data collection was interviewed till the target sample size of 600 was met. Any household that did not have an eligible respondent (i.e. age 60

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years and above) was skipped. One eligible respondent was selected from a household with two or more respondents.

2.3. Method of Data Collection

Quantitative data was collected through the use of a semi-structured questionnaire. The instrument was designed after reviewing related literature on perceived problems or challenges, needs and factors influencing care of the elderly with special reference to pertinent variables relating to perception, perceived needs, QoL, health challenges and factors influencing care of the elderly.

The design of the instrument was facilitated by use of adapted framework from combination of three theoretical frameworks, ecological model, PRECEDE model and Maslow's hierarchy of need. The questionnaire was divided into six sections (sections A-F). Section A focused on respondents' demographic information while section B consisted of questions that measured perception of respondents on the care they received, and section C included questions that measured the perceived needs of respondents. Questions on the health-related challenges faced by respondents were contained in section D; also section E was on questions for determining factors influencing the care the respondents received. Finally, section F was on questions on type and kind of social support received by the respondents in the community.

The questionnaire was translated to Yoruba language by someone who was versed in Yoruba and English. There was back translation to English by another person who was equally an authority in Yoruba and English with a view to verifying the accuracy of translation.

2.4. Data Analysis

A semi-structured questionnaire used had questions on socio-demographic characteristics, perception, perceived needs, health-related challenges and typologies of social support received. These were measured using QoL (36); Depression (30); General Health-GH (33); and Dementia (8) scales. Scores of ≤15 and ≥15-36 on the QoL scale were categorized as high and low respectively. Depression scores of 0-9, >9-19 and >19-30 were classified as normal, mild and severe respectively. The GH scores of ≤15, >15-20 and >20-34 were categorized as lack of distress, moderate distress and severe distress respectively. Dementia scores were categorized as follows: 0-2 (intact functioning), 3-4 (mild impairment), 5-6 (moderate impairment) and 7-8 (severe impairment).

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Open ended sections were coded and fed into the computer. The Statistical Package for Social Sciences 15.0 was used for data analysis. Data were analysed using descriptive statistics, Chi-square test and logistic regression at p=0.05.

3. Results

3.1. Respondents' Socio-demographic Information

Respondents' ages ranged from 60-95 years with a mean age of 67.7±7.1 years. A very large proportion (91.3%) were aged 69 years and below while few (8.7%) were above 70 years of age. Respondents within the 60-64 years age bracket constituted 66.3%, those aged 65-69 were 25.0% and 56.2% were male. Most respondents (38.8%) were pensioners without any major post-retirement occupation, followed by traders (26.2%), farming (12.0%), artisans (10.0%), civil servants (8.0%), and religious leaders (1.8%) as shown in Table 1. With regards to the highest level of education, respondents with no formal education (28.7%) topped the list, followed by those with secondary education (16.0%), primary education (14.9%), and trade test (10.3%). More than half (57.2%) of the respondents were Christians, followed by adherents of Islam (41.0%). Majority (89.2%) of the respondents were Yoruba, few were Igbo (7.3%) and fewer (1.3%) were Hausa

Most (78.1%) of the respondents were married, while few (15.0%) were widowed. Respondents who were divorced (3.5%), separated (3.2%) and single/not married (0.2%) are also shown in Table 2. Respondents in monogamous unions accounted for 61.8% while those in polygynous unions were 38.0%. Spouse and children (40.0%) topped the list of persons living with respondents, followed by children only (15.2%). Most respondents (60.0%) were living in flats.

3.2. Respondents' Income and Expenditure

More than half (52.8%) of the respondents received monthly income through pension. Trading/business provided monthly income for 22.9% of the respondents. Others received monthly income through salary (8.5%) and from children (5.4%). Table 3 also indicates that respondents often spent money on food/feeding (55.4%), housekeeping/family needs (9.4%), medicine/healthcare (7.0%) and children's education (5.6%).

3.3. Perceived Quality of Life among the Respondents

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The various levels of respondents' perceived QoL are highlighted in Table 4. The proportion of respondents who were not satisfied with their QoL at all was 17.8%; 12.0% were satisfied to a little extent; 33.4% were satisfied to some extent while 26.8% were satisfied to a great extent. Majority (64.4%) of the respondents perceived that their physical condition did not affect their QoL at all. Only 22% of the respondents said that their physical condition affected their QoL to a little extent; 9.8% said it affected them to some extent while 3.8% said it affected them to a great extent. Majority (82.0%) of respondents stated that their physical condition did not affect their relationship with people at all.

3.4. Gender Differentiation in Respondents' Perceived Quality of Life

The difference in respondents' perceived satisfaction with their present QoL by gender was statistically significant ($P<0.05$). Significantly more males (85.5%) than females (77.9%) were satisfied with their present QoL. There is also a statistically significant difference ($P<0.05$) in whether the physical condition of respondents affected the QoL of respondents; more males (70.6%) than females (56.3%) declared that their physical condition did not affect their QoL. Similarly, significantly more males (84.9%) than females (78.3%) stated that their physical condition had no adverse effect on their relationship with people.

4. Discussion

There is no standard definition for the term "elderly." According to the World Health Organization (2002), the elderly are described as people who are past middle age and approaching old age. Also, according to Active Aging (2002), an elderly person is one having authority by virtue of age and experience. The UN prescribed people aged 60 years and above as the older population (Global Action on Aging, 2005). However, in the developed countries like United Kingdom and United States of America for instance, significant proportions of the population aged 65 and above are considered elderly. Establishing the definition of elderly in Africa is difficult, because many people's actual birth dates are unknown; this is because many individuals in Africa do not have an official record of their birth dates (WHO, 2008).

Majority respondents in this study are predominantly from the Yoruba ethnic group. This is because Apete, the study setting, is located in the Yoruba speaking area of Nigeria. Findings from this study shows that there are more males than females and most of these respondents were married. A similar study carried out among

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the elderly in Ondo State by Olayiwola, Olarewaju, Adelekan and Arigbede (2013) revealed that males aged 60 years and above were more than the female participants. While limited to the study areas, this might imply that there may be more elderly males than elderly females in most parts of Nigeria having similar socio-economic and cultural conditions. Beyond Nigeria, similar studies carried out in Taiwan also revealed that majority of the elderly in a study were males, married with average age of 72.8 years (Min-Huey et al, 2007). If the majority of males is the case, then the feminisation of old age (United Nations Population Ageing and Living Arrangements of Older Persons, 2001) may not be accurate. However, since this studies are limited to the areas, further validation that may allow a definite conclusion on this point needs to be done.

Findings from this study also show that majority of elderly people in Apete currently live with their extended family, spouses and children; only a few proportion live alone. This suggests a parallel outcome with the study of Hung, Hung, Wu, et al (1991) who report that a significant proportion of elderly people in Taiwan lived with their spouses, children, or grandchildren with only 10.1% of such people living alone. The finding that two-thirds of all persons aged ≥60 years were currently married, with the percentage decreasing with age, also receives support elsewhere. Olayiwola et al. (2013) found out that most individuals aged ≥60 were married, with more men being married than women. This might suppose that the tendency to be unmarried increases with age, with women being more likely to be unmarried than men. Also, the higher proportion of women in widowhood might be because many of the women in Nigeria don't remarry again unlike men. As a matter of fact, the family structure among the Yoruba in Nigeria reveals that several men have more than one wife, and some are in the habit of marrying younger women at old age (Okumagba, 2011). This may have accounted for why more male respondents were married.

A higher proportion of respondents have monthly income, with pension topping the list of their sources. This could be attributed to the higher number of retirees living within the study location. The finding contradicts the study by Reno and Lavery (2007) which revealed that pension is a distant second to social security as a source of income, while income from assets ranks third, but this might be due to the fact that the study was carried out in a developed country. This also explains the inability of the government in setting up social security for the elderly in Nigeria. Also, the findings show that the sources of income from children are limited. This might be due to the economic situation in Nigeria.

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However, Olayiwola et al. (2013) observed in their study among the rural elderly in Ondo that an overwhelming majority of their subjects (>90%) aged ≥60 years were in the labour force, working to produce goods and services that contribute to national income. They argued that in relative terms, this demographic group of elderly contributes more to agricultural production than other groups in Nigeria. Even though this study was conducted in a peri-urban location, very few respondents still reported that they engaged in farming as their occupation.

Another finding shows that most respondents' expenditure was on food/feeding, followed by clothing. This finding contradicts a study by Walker and Schwenk (1991) perhaps because of the difference in the study areas. The researchers report that housing, food, transportation, and health care, in this order, takes the largest shares of the household budget for the elderly Their study also reveals that more than half of the respondents personally own the house in which they resided. A study among the elderly in the United Kingdom also finds that more than half of the respondents (63%) live in their own homes; while 29% rent from social landlords; and eight percent (8%) rented from private landlords (ONS, 2005).

A key finding in this study is that many of the respondents are satisfied with their present QoL. Thomopoulou, Thomopoulou and Koutsouki (2010) also report a similar finding in a study conducted among the elderly. According to the study, their respondents aged 60-74 years old express satisfaction with their perceived QoL. A study by Bowling, Seetai, Morris and Ebrahim (2007) based on four Omnibus Surveys in Britain find that over 80% of people aged 65 years and above report good QoL. McGee, Morgan, Hickey, Burke and Savva (2005) note that older men and women in Ireland affirm having a good QoL. They claim that despite the adverse changes that occur with increasing age, older people typically report high levels of well-being. Most feel younger than their actual age and maintain a sense of confidence and purpose. This could probably explain the reason, despite being in Nigeria, more than half of the respondents in this study claim that their physical condition does not affect their QoL. Most of them are also of the perception that their physical condition does not affect their relationship with people; this is indicative of their social wellbeing.

The result of this study also shows that there is significant association between the respondents' gender and perceived QoL. Jacobsson and Hallberg (2005) state that there is a gender differential in the influence of cultural and socioeconomic habits on QoL. More of the elderly males were of the perception that they had a better

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QoL compared to their female counterparts. This means that the perceived QoL of respondents could be influenced by their gender. Thomopoulou et al (2010) also confirm this development in their study.

A significant association between the respondents' gender and their physical condition has also been confirmed. This proves that the respondents' gender can influence their physical condition as the more male respondents report that they are in good physical condition compared to their female counterpart. These findings could be due to the fact that in Nigeria most elderly women are illiterate and often engage in physically-stressing work in their youthful years; this is in addition to the long-term effect of many labours in the process of childbearing. Women seem to experience more stress than men (World Economic Forum, 2012).

Many factors influence the QoL of older people. Well-being in later life is associated with higher socio-economic status, financial security and better education (Pinquart and Sorensen, 2000). Social integration also plays a key role; QoL improves with having trusting relationships and social contact (Pinquart and Sorensen, 2000; Netuveli, Wiggins, Hildon, Montgomery and Blane, 2006). The result of this study shows that age, educational status and living arrangements (demographic variables) have significant effects on the QoL of the elderly. Respondents within age group 60-64 years appear to be five times more likely to have high QoL compared to those who fall between age group 65-69 years and above.

This finding is similar to what has been documented in other countries. For instance, some researchers have observed that the QoL has an inverse correlation with age; that is, the older one becomes, the worse the quality of one's life (Motel-Klingebiel, von-Kondratowitz and Tesch-Romer; 2004). Butler and Ciarrochi (2007) also confirm the finding that old age and its impacts (e.g. hormonical changes, disabilities, and psychological deterioration) enhance the dependence on caregivers and reduce the QoL of the elderly.

This study also reveals that the respondents who are literate are two times more likely to have high QoL compared to those who are illiterate. This finding agrees with what McGee et al (2005) observe. They state that the QoL increases in the older population with the level of education; those with a tertiary education have the best QoL, while those who have primary or no education tend to have the poorest. There was a significant relationship between the living situation of respondents and their QoL. It has been revealed in this study that respondents who live with people are two times more likely to have high QoL compared to those that live alone. This also aligns with the finding of McGee et al (2005) that older people who live with a spouse or others have a better QoL than those who live alone.

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5. Conclusion

The study has identified that literate respondents are more likely to have high QoL compared to illiterates. Respondents living with people are more likely to have high QoL compared to those living alone. Furthermore, the health workers' unfriendly behaviour and cost of treatment are a major concern among respondents. Awareness on care of the elderly and special education for the elderly and their caregivers have been identified by the elderly respondents as ways to address their concerns.

The primary contribution of this study has been on the care of the elderly in Nigeria. Specific areas where individuals, communities, health professionals and policy makers could be involved in addressing the care and QoL among the elderly in the study area have also been identified. This contribution may be helpful in designing policies that address the challenges of old age, and adult health education and research.

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APPENDIX

Tables

Table 1: Respondents' socio-demographic information N=600

Characteristics		No	%
Age group:	60-64	398	66.3
	65-69	151	25.0
	≥ 70	51	8.7
Sex:	Male	337	56.2
	Female	263	43.8
Occupation:	Pensioner	230	38.3
	Trading	157	26.2
	Farming	72	12.0
	Artisan	60	10.0
	Civil servant	48	8.0
	Religious leader	11	1.8
	Politician	9	1.0
	Doctor	6	1.0
	Public school administrator	6	0.7
	Lecturer	3	0.5
	Private security officer	2	0.3
	Lawyer	1	0.2
Highest Level of Education:	No formal education	172	28.7
	Primary education	89	14.9
	Trade test	62	10.3
	Secondary education	96	16.0
	NCE	33	5.5

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	Diploma in Nursing/Midwifery	47	7.8
	Polytechnic (OND)	48	8.0
	Polytechnic (HND)	44	7.2
	Bachelor Degree	2	0.4
	Postgraduate Degree	7	1.2
Religion:	Christianity	343	57.2
	Islam	246	41.0
	Traditional African Religion	11	1.8
Ethnic group:	Yoruba	535	89.2
	Igbo	44	7.3
	Hausa	8	1.3
	Edo	7	1.2
	Middle belt ethnic minorities *	6	1.0

***Middle belt ethnic minorities includes: Kogi and Benue**

Family related information

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Table 2: Family related information

Family related information		**No**	**%**
Marital status: (N=600)	Single/Not married	1	0.2
	Married	469	78.1
	Divorced	21	3.5
	Widowed	90	15.0
	Separated	19	3.2
Type of marriage: (n=469)	Monogynous	251	49.1
	Polygynous	218	29.0
Type of family living with: (N=600)	Living alone	75	12.5
	Nuclear	380	63.3
	Extended	145	24.2
Persons living with respondents in same house: (House components) (N=600)	Spouse & children	240	40.0
	Children only	94	15.2
	Spouse, children and extended family	85	14.2
	Tenants	67	11.2
	Extended family only	60	10.5
	Spouse only	46	7.6
	No one/Living alone	6	1.0
	Housemaid	2	0.3

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Table 3: Respondents' income and expenditure

N=600

Variables		**No**	**%**
Whether have monthly income (N=600):	Yes	373	62.2
	No	227	37.8
Sources of income (n=373):	Pension	197	52.8
	Trading/business	85	22.9
	Salary/wage/allowance	31	8.5
	Children	20	5.4
	Artisan work	16	4.3
	Farming	15	4.0
	Son-in-law	4	1.1
	Driving	3	0.8
	Private medical practice	1	0.1
	Begging for alms	1	0.1
Respondents' monthly expenses (n=373):	Food/feeding	203	55.4
	Clothing	63	16.4
	House keep/family needs	43	9.4
	Drug/Health care	20	7.0
	Children education/welfare	17	5.6
	Personal needs	10	3.2
	Re-invest into business	8	1.8
	Rent	5	0.7
	Electricity bill	3	0.4
	Fuel	1	0.1

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Table 4: Perceived quality of life among the respondents

N=600

Perceived quality of life*	**Levels**			
	Not at all (%)	**A little extent (%)**	**To some extent (%)**	**To a great extent (%)**
Satisfaction with present quality of life	107(17.8)	132(22.0)	200(33.4)	161(26.8)
Influence of physical condition on quality of life	386(64.4)	132(22.0)	59 (9.8)	23 (3.8)
Adverse influence of physical condition on relationship with people	492(82.0)	82 (13.6)	22 (3.7)	4 (0.7)
Effects of physical condition or health problem on your finances	261(43.5)	203(33.8)	103(17.2)	33 (5.5)
Trouble taking a walk	256(42.6)	186(31.0)	127(21.2)	31 (5.2)
Challenges pursuing hobbies or other leisure ones used to enjoy doing	301(51.6)	165(27.5)	94 (15.7)	31 (5.2)
Staying in bed or a chair most of the time during the day due to advancement in age	385(64.2)	150(25.0)	53 (8.8)	12 (2.0)
Have trouble sleeping	357(59.5)	163(27.2)	75 (12.5)	5 (0.8)
Have problem with self-care (i.e. increasingly rely on people to care for you)	358(59.7)	156(26.0)	66 (11.0)	20 (3.3)
Physical health condition often making ones unhappy	485(80.9)	68 (11.3)	26 (4.3)	21 (3.5)
Felt so sad that one's wondered if anything worthwhile within last one year	435(72.5)	119(19.8)	37 (6.2)	9 (1.5)
Felt so hopeless that one's wondered if anything worthwhile within last one year	472(78.7)	95 (15.8)	16 (2.7)	17 (2.8)

***Quality of life is personal satisfaction or dissatisfaction with the cultural, health or intellectual conditions under which one lives**

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Table 5: Gender differentiation in respondents' perceived quality of life

N=600

Perceived quality of life	**Yes (%)**	**No (%)**	**df**	**X^2**	**P-value**
Are you satisfied with your present quality of life: Male Female	+ 288(85.5) 205(77.9)	49(14.5) 58(22.1)	1	5.691	0.02*
Does your physical condition affect your quality of life: Male Female	99(29.4) 115(43.7)	+ 238(70.6) 148(56.3)	1	13.256	0.00*
Does your physical condition adversely affect your relationship with people: Male Female	51(15.1) 57(21.7)	+ 286(84.9) 206(78.3)	1	4.280	0.04*
Is your physical condition or health a problem to you financially: Male Female	183(54.3) 156(59.3)	+ 154(45.7) 107(40.7)	1	1.510	0.22
Do you have any trouble taking a walk: Male Female	181(53.7) 163(62.0)	+ 156(46.3) 100(38.0)	1	4.128	0.04*
Do you have challenges pursuing your hobbies or other leisure which you used to enjoy doing: Male Female	159(47.2) 131(49.8)	+ 178(52.8) 132(50.2)	1	0.409	0.52
Does your physical health condition often make you unhappy: Male Female	112(33.2) 103(39.2)	+ 225(66.8) 160(60.8)	1	2.258	0.13
Do you have trouble sleeping: Male	122(36.2)	+ 215(63.8)	1	5.894	0.02*

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Female	121(46.0)	142(54.0)			
Do you have problem with self-care (i.e. you increasingly rely on people to care for you):		+			
Male	131(38.9)	206(61.1)	1	0.682	0.41
Female	111(42.2)	152(57.8)			
Does your physical health condition often make you		+			
unhappy: Male	56(16.6)	281(83.4)			
Female	59(22.4)	204(77.6)	1	3.225	0.07
Have you ever felt so sad that you wondered if anything was worthwhile within last one year:		+			
Male	87(25.8)	250(74.2)	1	1.094	0.30
Female	78(29.7)	185(70.3)			
Have you ever felt so hopeless that you wondered if anything was worthwhile within last one year:		+			
Male	62(18.4)	275(81.6)	1	3.948	0.05*
Female	66(25.1)	197(74.9)			

*significant +Perceived positive QoL

Categories of Quality of Life (QOL) of respondents

Majority (90.1%) of the respondents had high quality of life while very few (9.9%) had low quality of life.

Table 6: Categories of Quality of Life (QOL) of respondents

N=600

Categories of Quality of Life (QOL)	**No**	**%**
High QOL (<15)	541	90.1
Low QOL (>15)	59	9.9

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The male-female differentiation in respondents' quality of life is depicted in Table 7. The proportion of males with high QoL was 89.9%. This was not significantly different from the females (90.5%)

Table 7: Male-female differentiation in respondents' QOL

N=600

Sex/gender	QOL		Subtotal	Df	X^2	P-value
	High (%)	Low (%)				
Male	303 (89.9)	34 (10.1)	337 (56.2)	1	0.057	0.81**
Female	238 (90.5)	25 (9.5)	263 (43.8)			
Total	541 (90.2)	59 (9.8)	600 (100.0)			

**Not significant (P>0.05)

Building the regression test started with the inclusion of all possible factors (independent variables) that could predict quality of life. However, those that were found not to be significant were excluded from the final analysis. Only those that were (significant) variables were included in the final model. There was a significant relationship between age and quality of life. Respondents within age group 60-64 were five times more likely to have high quality of life compared to those who fell between age group 65-69 and 70+ (OR: 4.9; 95% CI: 2.2-11.0). There was also significant relationship between respondents' educational status and their quality of life. Respondents who were literate were two times more likely to have high quality of life compared to those who were illiterate (OR: 2.5; 95% CI: 1.2-5.0). Furthermore, there was a significant relationship between living settings/situation of respondents and quality of life. Respondents who were living in company of family, relative, children, wife or husband were two times more likely to have high quality of life compared to those that were living alone (OR:2.2; 95% CI: 1.2-4.0).

Table 8: Regression results relating to the determinants of respondents' quality of life

	S.E.	Df	Sig.	OR	95.0% C.I. for OR	
					Lower	Upper

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Selected covariates						
Age:						
(60-64)	0.415	1	0.00*	4.892	2.181	10.975
(65-69)	0.407	1	0.38	1.428	0.644	3.169
70+		2				
Educational status:						
Literate	0.356	1	0.01*	2.483	1.235	4.992
Illiterate		1				
Educational level:						
No formal education	0.356	1	0.31	0.403	0.200	0.810
Primary education	0.445	1	0.33	0.644	0.269	1.539
Secondary education	0.774	1	0.35	2.067	0.454	9.418
Tertiary education		3				
Living settings/situation:						
Living with people*	0.308	1	0.01*	2.168	1.184	3.968
Living alone*		1				
Monthly income status:						
Yes	0.342	1	0.27	1.459	0.746	2.854
No		1				

*significant

*living with people: staying with family members, relative, children, husband or wife

*****living alone: staying alone at home without any person

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