



OLD PEOPLES' WELL BEING IN A TOTAL INSTITUTION AND THE IMPERATIVE OF NEW POLICY DIRECTIVE

OWUMI B.E¹, TAIWO P.A² and OLAOTAN, S. Y³.

*Department of Sociology,
Faculty of the Social Science,
University of Ibadan*

1. bowumi@yahoo.com
2. pataiwo@gmail.com
3. yolaotansamiah@yahoo.com

ABSTRACT

In contemporary times, African as well as Nigerian societies have experienced changes due to urbanization, globalization, and industrialization. This has resulted in a weakening of the hitherto existing bonds, norms, values and culture in the family structure with the attendant consequences of neglecting the elderly. While studies have focused on the factors militating against adequate care for the elderly, psychological well being of the elderly as well as their unmet needs, dearth of information exist on the social well-being of the elderly who are under care and support in the institution such as the Yaba old people's home. This study was conducted against this background with the social exchange theory and Health Belief Model as its theoretical frameworks. The study was purely qualitative using in-depth interview with 44 resident aged people, 3 key informant interviews with staff of the institution and non-participant observation as the methods of data collection. Over half (59.0%) of the respondents are female while about a quarter of the respondents (23.0%) most of whom were females, had no education. Furthermore, while 91.0% were between the ages of 71-90years, 98.0% of the respondents were widowed prior to their admission into the homes. Findings revealed that the elderly experienced dissatisfaction with the food, access to medical attention and condition of living in the institution. This was revealed to be because they lacked choice as to what to eat, where to stay, who to stay with and when to receive medical attention. Lack of adequate funding from government, inconsistent payment from relations of the elderly, and limited supplies of resources were reported as the challenges faced by the institutions which affected the care of the elderly in the home. Adequate funding, consistent payment and increased support from government, clients relations and other necessary stakeholders respectively are recommended in order to ameliorate the conditions of the aged in Nigeria in particular and African in general.

Key Words: Poverty, social Wellbeing, Institutionalization

BACKGROUND/ STATEMENT OF THE PROBLEM

A basic assumption of social gerontologists is that the individual's aging experience is largely determined by social and cultural factors. This implies that the society largely determines the way old age is perceived. The negative or positive views held by members of society about aging affect both the social, physical care and treatment given to the elderly population as well as the way individuals live their old age. (Levy and Leifheit-Limson, 2009). In general, the ideas about aging tend to associate it to physical problems (low physical attractiveness, physical inactivity, dependency, disability, illness and death) to interpersonal changes, such as bad temper, depression, unhappiness and isolation and to cognitive deterioration (Gureje, Lola, Ebenezer and Benjamin 2008, Ejikeme , Ejikeme, Badru, Akwash 2014)

However, despite all of the above problems associated with old age, the traditional African society placed the care of the elderly in the hands of children, members of the extended family, and community members as they provided care and support for the elderly (Eboiyehi, 2008). This responsibility of caring for the old was seen as a collective responsibility and expectation of the entire society. In recent times however this is neglected to the extent that social security, health care services and other essential services have become lacking among the elderly (Isiugo-Abanihe 2014). Poverty among the elderly was minimal as this group of people was respected and treated as custodians of the traditions, customs and way of life of the



society (Akinyemi and Akinlo 2014). However, in a fast-paced industrializing and modernized society, the above does not characterize the society any more (Ting 2012 as cited by Ibitoye, Sanuade, Adebowale, Ayeni 2014). The cultural belief that the extended family members are responsible to cater for the needs of the aged contributes greatly to their neglect. Although the family forms the cornerstone of care and support for the elderly, recent studies have shown that the quality of life, meanings, opportunities and future perspectives for most elderly in Nigeria are those of poor, marginalized and generally dependent (Eboiyehi, 2008).

The breakdown of traditional system of family pattern from extended family living to increase nuclear patterns has led to a rise in the institutionalization of the elderly. The urban setting, which gives little or just about enough space for a single unit of family, makes it more difficult to reside with elders who may pose further strain on the family. It is therefore not surprising that the society has evolved a new pattern of residence for the elderly. This is mostly reflected by establishment of total institution, which house the elderly and serves as permanent abode for them for the rest of their lives. This institution, it is argued will separate them from the larger society, bringing together people in like situation in order to be able to cater more for their needs, reduce incidences of elder abuse and enhance their wellbeing by placing their care in the hands of skilled care givers.

In Nigeria, total institutions such as old people homes for the aged are not very common but exist in some parts of the country. This may be due to the persistent strong belief in traditional values even in the face of growing urbanization and nuclear family structures. Various studies have shown that institutionalized elders have persistently suffered abuse and neglect from caregivers. Anderson and Dabelko-Schoeny (2010) noted that institutionalized elderly seem to experience the aging process more negatively and as 'waiting for death', becoming more socially and emotionally isolated. What is however lacking is how poverty in their peculiar circumstance affects their wellbeing as institutionalized elders separate from elders outside such institutions.

In recent times, most studies have tended to focus on the incidence and prevalence of abuse and poverty among the aged. This involves and includes the negative stereotypes about old age and abuse of the elderly all over the world which has been attributed to have existed from a ancient times World Health Organization (WHO, 2002) . Although the family forms the cornerstone of care and support for the elderly, recent studies have shown that the quality of life, meanings, opportunities and future perspectives for most elderly in Nigeria are those of poor, marginalized and generally dependent (Eboiyehi, 2008; 2009).

There are however, reasons to think that there are differences between the level of poverty and wellbeing among non-institutionalized and institutionalized elders in society. This has been suggested in the work of Anderson & Dabelko-Schoeny (2010) who noted, "Differences have been found between institutionalized and non-institutionalized elderly. Institutionalized elderly seem to experience the aging process more negatively and as 'waiting for death', becoming more socially and emotionally isolated". Unfortunately, not much specific empirical studies exist on the social well being/ healthcare of the elderly in total institutions in any state in Nigeria. The study attempts to fill this gap.

Given the usual nature of the Nigerian government to in-adequately put in place policies that ameliorates societal discomfort of any kind, and given the rise in corruption in the country, it



is pertinent to study the effect of certain poverty indicators on the wellbeing of the elderly in total institutions in Nigeria. It is against this backdrop that the study focuses on Lagos state, a metropolitan state whose state government has established a total institution that is home to the aged. The paper specifically attempted to examine the wellbeing of the aged in the institutionalized home by investigating their access to nutritional and medical care and general condition of living in Yaba home for the aged.

TOTAL INSTITUTION AND WELLBING OF THE ELDERLY

The concept of well-being has been subjected to several description and explanations which are mostly relative and subjective in nature. Sarah (2008) identified three dimension of wellbeing which are subjective, relational and material. The subjective wellbeing concerns values, perception and experiences, the relational concerns personal and social relations, while the material wellbeing concerns practical welfare and standard of living. Dodge, Daly, Huyton, J. and Sanders (2012) defined wellbeing as “when individuals have the psychological, social and physical resources that they need to meet a particular psychological, social and/or physical challenge.”. They further identified three key important areas in understanding the concept of well being which are, the idea of a set point for wellbeing; the inevitability of equilibrium/homeostasis; and the fluctuating state between challenges and resources.

Total institution is viewed as a place of work and residence where a great number of similarly situated people, cut off from the wider community for a considerable time and also live an enclosed, formally administered round of life. (Erving Goffman 1957). A total institution may include juvenile home, prison, old people’s home, hospitals, mental clinics as well as other correctional homes. Institutional residences for the elderly are some of the systems in place that could be perceived to be providing support to vulnerable elderly. Institutionalized populations are normally divided into two groups: short term and long term. The short-term group consists of people residing in the nursing home for less than six months (usually discharged to home and the community after rehabilitation, back to the hospital or discharged secondary to death). The long-term group consists of the older, frailer resident. There are a number of factors that are predictive of institutionalization. Five major factors are: Loss of Physical Function, restricted mobility, social resources and support, health perception and socio-economic status.

The World Health Organization (1946) defined health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. As Gordon (2005) noted, health is a very important indicator of poverty and wellbeing among a group of people. He went further to affirm that ill-health is one of the various forms of absolute poverty. Stanislav (1972) went ahead to suggest that certain kinds of life events may affect the health of an individual either positively or negatively. He noted that institutionalization is a type of life event which represent for most individuals major changes in their lives. For the elderly, who are a particularly vulnerable group from the economic and socio-medical perspective, these events could indeed have major health consequences.

SOCIAL EXCHANGE THEORY

The origins of social exchange theory in sociology are reflected in the classic formulations by Homans (1961) and Blau (1964) and work in economics assuming a rational model of decision-making behaviour developed in the 1930s. In social gerontology, Dowd (1975) and Bengtson and Dowd (1981) drew from these theorists to suggest that the reason



there was decreased interaction between the old and the young, relative to the middle-aged and the young, was that the old had fewer resources to offer in their social exchanges and thus had less to bring to the encounter. More recently, research in the areas of social support and intergenerational transfers has used the social exchange framework as a starting point for explanations of the occurrence of intergenerational social and financial exchanges, the structure of exchanges (who gives and who receives), and the patterns of these exchanges under varying conditions.

This perspective in its application attempts to account for exchange behaviour between individuals of different ages as a result of the shift in roles, skills, and resources that accompanies advancing age (Hendricks, 1995). Furthermore, a central assumption in the social exchange framework is that the various actors (such as parent and child or elder and youth) each bring resources to the interaction or exchange, and that resources need not be material and will most likely be unequal. A second assumption is that actors will only continue to engage in exchanges for as long as the benefits are greater than the costs and while there are no better alternatives (Hendricks, 1995). Third, it is assumed that exchanges are governed by norms of reciprocity (Gouldner, 1960): when we give something, we trust that something of equal value will be reciprocated. The key concepts used in social exchange explanations include social costs and benefits, social resources, social interaction/contact, reciprocity norms, social power, and altruism.

Exchange theory has been used as an explanatory framework in many recent studies in the sociology of aging, particularly those focusing on intergenerational social support and transfers. Hogan, Eggebeen, and Clogg (1993) found that social support exchanges in families are either constrained or aided by family structure, including opportunities for family interactions, and by family needs, all part of the social resources brought to bear on exchanges in families. At the micro-social level of analysis, Bernheim, Shleifer, and Summers (1985) reported that contact between parents and children was greater when parents had a larger amount of "bequeatable wealth." This supports earlier work by Sussman, Cates, and Smith (1970), which indicated that children who took care of their elderly parents inherited the largest share of their parents' property. In both studies, exchanges persisted because adult children judged the benefits of an inheritance to be greater than the costs parental dependency entailed.

The major contributions of exchange theory in the sociology of aging include its ability to explain exchanges of contact and social support, as well as how emotional, social, or financial resources influence these exchanges. Current social exchange theories of aging emphasize that interaction may be driven by emotional needs and resources (for example, altruism in the case of social support) rather than merely the rational calculation of costs and benefits (which has been a criticism of past exchange formulations). Implicit in exchange theory is the notion of power, that individuals with greater social resources or interactional opportunities have more power in exchanges.

The Health Belief Model

The HBM attempts to predict health-related behaviours in terms of certain belief patterns (Rosenstock, Stretcher and Becker 1988). This model is used in explaining and predicting health behaviour, as well as sick-role and illness behaviour and stipulates that a person's health-related behaviour depends on the person's perception of four critical areas: **Perceived Susceptibility**. Which depicts that the elderly and their care-givers vary widely in their perception of susceptibility to disease or condition such that those at low end of the extreme perception of susceptibility, deny the possibility of contracting an adverse condition or disease,



while those in a moderate category admit to a statistical possibility of disease susceptibility. On the other extreme, are individual who feel high susceptibility and believe that there is real danger that there can be experience of an adverse condition or a given disease and these influence their decisions and actions to request for health care or ensure that the aged are cared for. **Perceived seriousness:** Which refers to the belief that the elderly or their care-giver hold concerning the effect that a given disease or condition would have on the state of affairs/health of the elderly person concerned **Perceived benefits of taking action:** which explains that the elderly people or their care-givers will take action toward the prevention of and seriousness of disease or condition or towards dealing with an illness as a next step after an after they have accepted the susceptibility of a disease and recognized its seriousness. **Barriers to taking action:** explains that action for instance may not take place the elderly or caregiver believes that the benefits to taking action are effective. Such barriers may include challenges of bureaucratic processes of decision making regarding providing health care for the aged or waiting for approval for family members of the aged, lack of funds, lack of adequate medical facilities, nonchalant attitude of staff, lack of medical personnel to mention but few. The model also incorporates **cues to action**, which refers to cue or a trigger to appropriate action such as decision of one's spouse, information from mass media and opinions and approval from one's relatives.

METHODOLOGY

The study was conducted in Lagos state, Nigeria. The state was chosen due to its metropolitan nature, structural transformation, increased basic amenities and social infrastructures in the last five years. More importantly, the institution used for the study the Old People's Home Yaba, was located in Lagos State and this institution is the only government owned institution for the elderly in Lagos state. The study was purely qualitative partly due to the need for in-depth information on the subject matter as well as the limited number of respondents in the home. Three (3) qualitative research methods were used to collect data and generate necessary information namely for the study. These included in-depth interviews (IDIs), key informant interviews (KIIs) and non-participant observation. These served as the primary source of data while secondary source of data was gotten from file records and published materials. The study population included aged males and females in the institution and officials of the institutions In-depth interviews were conducted with Forty four (44) residents aged people both males and females in the home, three key informants who were members of staff at the institution. Due approval was gotten from the Ministry of Youth and Social Development grant permission for the study to be conducted in the home. Furthermore, every participant in the study was granted their consent and were given the right to participant voluntarily and withdraw at anytime. They were also assured of confidentiality of their response and no physical harm came to them during the course of the study. Data generated was transcribed and analysed thematically.

DISCUSSION OF FINDINGS

Socio-demographic Characteristics of Respondents

Table 1. Presents the socio-demographic characteristics of respondents at the Old People's Home in Lagos, about 60% of the respondents are females. This dominance of females in the home reflects the level of vulnerability despite their higher longevity than their male counterparts. This corroborates the World Fact Book (2014) which estimated the life expectancy rate in Nigeria to be about 52 years for males and 54 years for females and Aina (2012) that



women are more vulnerable to poverty. Most of these females however were comprised basically of individuals rescued from one location or the other by government and other individuals and mostly referred to as destitute. Again, the destitute could have remained more of females who may find it difficult to remarry (a disadvantaged experience of most widow who may have been abandoned by their family members, accused of killing their husbands and even discriminated against or marginalized accessing care from their husband's family members and therefore have nowhere to go)

Table 1: Socio-demographic Characteristics of the aged people in the institution (N=44)

	Frequency	Percentage %
Sex of Respondents		
Male	18	41.0
Female	26	59.0
Age Group of Respondents		
71-80	25	57.0
81-90	15	34.0
91-100	4	9.0
Marital Status		
Married	1	2.0
Widowed	43	98.0
Educational Qualification		
No Education	10	23.0
Primary Education	8	18.0
Secondary Education	15	34.0
First degree	10	23.0
Postgraduate	1	2.0
Ethnic Group		
Yoruba	35	80.0
Igbo	8	18.0
Hausa	1	2.0

Also, it was observed that most of the females were engaged in petty trading prior to staying in the home. Findings also revealed that 91 percent of the respondents in the institutions are within the age group of 71 to 90 years of age, while 98% were widowed. Thus, while the former accounted for the period when elders can be largely dependent and require adequate care, and it can also be deduced that having lost their spouse, the elderly have lost their closest companions and are therefore likely to be lonely. This was confirmed by the fact that most of the respondents lost their spouse prior to staying in the home and therefore were brought there as



part of the strategies they needed to adopt in coping with the loneliness of being without their “better halves” who were usually their care-givers especially for most of the males.

About a quarter (23.0%) of the respondents had no education, majority of who are females. Also, about a quarter (23.0%) of the respondents who have a first degree are mostly males and mostly engaged in formal occupations before retirement and admission into the home. They were also reported to have access to one form of old age income or another such as pension or gratuity. Only one of the respondents had a postgraduate degree in International relations. Most of the respondents (80.0 %) are Yoruba. This may be due to the location of the home in the south western city of Lagos.

Nutritional Well-Being of the aged in Yaba Home

The study revealed that many of the respondents were destitute and rescued from various locations by individuals or government officials who thought they needed help and care. However, although the home is administered by the government, the livelihood of the occupants is not maximally guaranteed as relatives who should have supported were hardly ever found. From the in-depth interviews conducted in the home, some respondents narrated their lack of satisfaction with reference to the type and quantity of food they were given to eat in the homes. They added that they experienced lack of choice in the type of food they ate at the institution and the restriction they experienced in trying to get one outside the institution by saying:

...Although the home provides three course meals in a day, it is however the case that most times I am not able to eat the food because they are not meals I am used to. The management has done nothing to provide alternative which I could have if I was outside. We are not allowed to buy food either. I sometimes request for banana which I love so much but is usually declined.. (IDI/ Igbo male resident/ 71 years)

Interestingly another respondent complained about the food with reference to the quantity by saying:

I eat a lot and it seems like we are all given the same proportion of food. I am a man and these foods they give me here do not satisfy my hunger at all. I have complained so many times and nothing has been done to it. I feel hungry not quite long after I have eating. Nobody visits me so I hardly have provisions on my own. I really want them to improve on the quantity of food they give to me. I am not happy with my feeding. (IDI/ Male resident 83 years)

The above responses go further to reveal some level of dissatisfaction especially by the males with respect to food. Some other experiences narrated by the aged are understood to be so because of the features of the home which in itself is a total institution. Some respondents complained that they are indirectly stripped of their freedom of movement (with very little or no visits from relatives for some while) and choice. These issues could directly or indirectly affect the psychological well-being of the aged the institution. For instance, a respondent also expressed her worries by adding that she lives on the clothing donated by churches and could not go out to buy one because there are no privileges for that:

I live basically on cloths that I had for a long time, especially the ones I brought from my house. I have spent over 8 years in the home and no one has brought me cloths and I have been given new ones which were donated to the home only once which is even what I am wearing now as today is our fellowship day. Even if I want to go to the market, there is no one to take me there. Although the home has



a bus and even a car, it is mostly used for emergency cases, maybe when one of us is not feeling fine and needs immediate medical attention...(IDI/ Female resident /75years)

Another elderly confirmed this response by saying said:

...here we live basically on donations. As you can see yourself, churches have been coming to donate and talk to us. I know the ministry at Alausa is in charge of this place, but those people do not have our time. The truth also is that those of us whose relatives are supposed to pay monthly maintenance fees have been failing to do so also. If money is not available, then there is little the management can do to provide for us. (IDI/ Female resident/74 years)

Another respondent complained about the living condition and reiterated her experience of lack of choice even with reference to who she lives with by saying:

I am not allowed to choose who I live with. I do not like my roommate because she is dirty and when the care-givers come to clean up our room, she scatters the room all over. When I stayed with my child, I had a choice as to who comes in and out of my own room even if not the whole house (IDI/ Female resident /73 years)

From the key informant interviews conducted with the staffs in the Old People's Home, more information about the livelihood of the elders in the home was gotten. A key informant has this to say about the livelihood of the elders,

The old people's home is an institution under the ministry of youth and social development. This implies that the institution is government owned and should be fully funded by the government. However, because of lack of adequate funding from government, the home had to charge monthly maintenance fee from the referral groups of elders so as to help in the maintenance of the home. (KII/ Male staff, a social worker at the Old People's Home, Lagos)

He went further to talk about modalities for payment and expressed the challenges faced with regards to funding the Home which make it difficult for the institution to adequately meet the needs and demands of the aged by saying:

The modality for payment is such that at admission, the person or group that brings the elder pays 6 months advance fee. After this, they are expected to pay monthly. It is however the case that they most times do not show up after the six months to continue with subsequent payment of the fees. The home is therefore left with whatever is gotten from government which is most times not substantial enough and the little gotten from referral payments which are also not consistent. Although we get donations from organizations and individual, all put together cannot adequately take care of the needs of the elders substantially. (KII/ Male staff, a social worker at the Old People's Home, Lagos)

In the same vein, another respondent during the key informant interviews corroborated the above views and added that they sometimes refuse to meet the needs of the aged for fear that such will set precedence for others to keep making demands that may be uneasy to grant by saying:

Most elders demand for certain things which we are not able to give them. Sometimes, the demands are a bit huge and may affect our expenses. At other times they are little things, but granting them for one person will give room for others to ask for different things which we might not be able to grant. This may include daily things like newspaper, fruits, and clothes. As for the clothes, some of them have stayed up to 8 years in this place and have not been opportuned to get a new clothes for more than



once or twice, although we try our best to make sure the one's they have are always clean. (KII/ Male staff at the Old People's Home, Lagos)

The above response was confirmed during non-participant observation whereby, an occupant was observed to have demanded for fruit which a care giver told him could not be given to him. He repeatedly requested the banana saying,

"...you know I like banana and groundnut so much. Please tell them to get me banana and groundnut, I want banana..."(Non-participant Observation/on Male resident at the Old People's Home, Lagos)

Again this depicts the level of dependency of the elders to the point where they are deprived of their needs and demands like children not necessarily because it has adverse implication for the well-being or it is unavailable or unaffordable, but because the individuals in charge are in position to determine "who gets what"

On another occasion, it was gathered through non-participant observation that occupants of the home quarrel over materials. On this particular occasion observed, a female occupant requested for tissue paper. Thereafter, a male occupant who was later identified to be a doctor before retirement asked that the female occupant's request should not be granted. He went further to explain to his co-occupants who asked him not to interfere that the female occupant is in the habit of requesting for same and that it makes the tissue to finish within a short period of time, noting that she was not the only one who has use for tissue. This resulted in a loud argument with the co-occupants taking sides with either of the aggrieved parties.

From the foregoing therefore, there is lack of control in the circumstances surrounding their wellbeing by the elders themselves. Choices available to occupants in total institutions are limited. This is because they can only have access to what is made available to them in the institution. This can be seen in the limited access to material possessions such as cloths, sport facilities and even limited associations (in terms of religious affiliations) available to belong to. This in essence signifies a degree of loss of control over circumstances surrounding them. This loss of control and choice may heavily affect the self-perception and invariably the wellbeing of the elders. Lefcourt (1973) best sums up the finding by noting that:

".....the sense of control, the illusion that one can exercise personal choice has a definite and a positive role in sustaining life"

It is not surprising therefore that the factors of choice and control are important in accessing the wellbeing and poverty status of elders in institutions. This is because, as noted by Adamson and Schmale (1956) a feeling of helplessness and loss of hope experienced by institutionalized elders may affect their health conditions and promote heart diseases among the elders. Alternatively, control has generalized benefit of physical and mental alertness, activeness and a general level of satisfaction.

Moreover, even though the institution is a public establishment, inadequate funding affects the poverty and wellbeing of the elders resident in the home. This is mainly due to the inadequate funds received from government and also, the default in payment of fees by families who are expected to pay monthly allowance. This may further be made obvious by the limited sources of funds except from the two mentioned available for the administration of the home. The situation aggravates the limited choices available to the occupants and further increases their poverty and reduces the quality of their wellbeing.



ACCESS TO HEALTH CARE AND WELLBEING OF ELDERLY IN TOTAL INSTITUTION

Finding revealed that some of the respondents in the home that was studied were experiencing health challenges that affected their eyes, teeth, legs and usually were not given adequate medical attention perhaps because it was perceived mild or there were health personnel and medical facilities in the home. This generally affected their physical and social wellbeing. Some responses in this regards included one given by a male respondent who said

... a few months ago, I began to notice that my tooth aches. I told my care giver what I observed and she wanted me to wait for some time in order to determine if I had eaten something that is stucked in my tooth. However, after a few days, the pains increased and my mouth began to swell. I was not given any drugs because my family had not paid my monthly fee. Although, I was given pain relieve tablets, just to ease the pains, I didn't get medical attention as I ought to. A month back, some doctors on medical outreach came to pay us a visit and I was opportune to have a dental test for my tooth. They made some recommendations which till today remain recommendations with no action. Now as you can see, my mouth is swollen...(IDI/ Male resident/75 years)

In the same vein, another respondent narrated her health challenges as it affected her by saying:

Although I have always had this problem with my leg even before I came to stay in the home, I thought the government will provide me better care in the home. I was told that I can only have access to first aid drugs since my relatives have not paid my monthly allowance for a long time. So, I have been managing my leg like that and I can hardly climb down the stairs because of pains. All I need is a physiotherapist (IDI/ Female resident/89 years)

Another resident responded by commending the effort of the Home on their care-giving services. He however concludes with complaint of having health challenges with regards to his eyes and legs which have not received adequate health care attention despite the complain:

I was brought to the home by my brethren at the mosque in Ebute Metta. I know they try as much as possible to take care of us here, but for me, that is the personal effort of the management. My eyes have been glued together for a while now and I haven't being seeing with it. I don't even have an eye drop to take for it, yet it pains me regularly. Also, I have complained of my legs. They are swollen and I rarely leave my room except to pray. There are no drugs or anything else for that..(IDI/ Male resident/ 74 years)

Another respondent corroborate the above response by also adding that inadequate funds and support is a major factor that is militating against their access to adequate health care services said:

I have eye pain all the time. I wear this shade so as not to expose my eyes. I get drugs here quite alright but I feel it will be better if I can see a doctor. It all has to with funds. There are insufficient funds here in the home and that is why I have not gotten access to adequate health care...IDI/ Female resident/ 72 years)

Another respondent added that the ailments which are peculiar to the aged are due to their position as aged people and resulted from their past activities during their youthful age. He stated that despite the proximity of tertiary healthcare facilities around, health care services are only sought in emergency situations. This is perhaps affected by issues such as the perceived level of severity attached to ailment and the need to save cost due lack of funds



".....almost every one of us here has one health issue or the other. That is not uncommon due to our age. In old age, you develop one ailment or the other as a result of the life and work you have lived in the past. Except there is an emergency, most of us are given basic first aid care and not any professional attention for our different complications. But in the case of an emergency, there are general hospitals close to this place that the patient can be taken to. There is also a bus and a car available for such situations... (IDI/ Male resident/79 years, Lagos)

From the key informant interviews conducted in the home, more information was derived on the accessibility to health facilities of the occupants and their wellbeing. A key informant has this to say:

...most time, some of these elders had one ailment or the other before admission into the home. On admission, we conduct a medical checkup for each one of them to ascertain their health status. We try as much as possible to make them happy as this can boost their health status. We conduct ward round exercise in order to check them every day and know what is wrong with them. However, when they need special attention by a medical personnel, we do only what is within our resources. For those whose family and relatives are supposed to pay monthly maintenance fee, most of them have being defaulting in that aspect..

He continued by the narrating the dilemma they face in making decisions regarding the health of the elderly which is usually affected by bureaucratic rules on the need for the family to give their approval. Such he added was necessary in order to avoid the consequences of complains and dissatisfaction expressed by the family when they do not. The staff confirmed the above by saying:

We cannot take up the issue of an elder's health except an approval is given by the family because the family is supposed to pay for the hospital bills. Also, there had been instances where we take up certain issues and the family complained of not being carried along even though the situation was an emergency. On another occasion, we were accused of given an occupant a medications which the relatives claimed affected the occupant. Because of this various issues that have arisen in the past, the management has decided not to intervene in the health issues of occupants except in cases where it is utmost necessary and also in case where the occupant is a destitute and solely the responsibility of government. We have first aid care for basic injuries and pains, but all other major health issues are taking to general hospitals around us on approval....."(KII/ Male staff at the Old People's Home, Lagos)

Another key informant said:

...some of the occupants have cases of dementia, amnesia etc. memory loss is not uncommon here. In such cases there is nothing we can do except try to get the relatives to see to the case. However, most of them see this place as a dumping ground where they drop their parents and never look back. If they do not check on their parents and we take up the matter, we may be blamed later on if anything happens to the occupant...(KII/Male staff at the Old People's Home, Lagos)

It was further observed that while in the home, a number of the occupants suffer from memory loss. Some were physically challenged and hardly leave their room because of one ailment or the other. It was also observed that drugs are dispensed in cases of general body pains but not for any major medical issue. However, the care givers were observed to attempt to make the occupants happy. They sing and dance with them. On a particular occasion, a social



worker noted that an occupant recalls incidences only when she listens to music which she listens to at the time of the incident. There was another occupant whom a care giver noted suffered from depression because she lost all her children on the same day. During the observation, the only sport facility available in the home is a table tennis which is mostly deserted. Most of the respondents noted that they could not play the game and only few showed interest in any other sport even if it was available. It was however observed that sports are not encouraged not enforced in the home. Exercise includes dancing, clapping, stretching of legs among others. No rigorous exercise is engaged in.

The study found that residents in the institution perceive themselves as having low access to health care and health facilities. These finding is confirms the views of Murillo et al. (2006) who posited that good health strengthens the autonomy and self-image of the elderly. Regarding the health perception of the elderly however, they noted that subjects in institutions are more likely to evaluate their health more negatively and have images associated with illness, grief, dependency and disability. A major determinant of poverty and wellbeing is the health status of a group of people. As people get older, their health care needs change. Older people often do not know the clinical effects of ageing, or lack the resources to meet their health care needs. Many older people experience chronic poverty, and this exacerbates the degenerative effects of ageing, such as hypertension, malnutrition, anemia, diabetes, osteoporosis, rheumatism, and hearing and eyesight problems. Institutionalized older people's access to health care is limited by a number of factors including:

- being unable to pay for transport to get to the health center, or for the medication
- lacking the right identity documentation to prove their eligibility for free or subsidized services
- being unaware of what they are entitled to
- being physically unable to queue for a long time while waiting to be seen, or to take an arduous journey to the health centre by public transport
- being geographically isolated from services, with a lack of public or private transport.

These factors are compounded by the fact that workers at the institution may not have been trained in geriatric care and may therefore not be able to give immediate and first aid help to elders in need.

CONCLUSION

Institutionalization represents a major life changing event for most elders which could affect their physical, psychological and social wellbeing. While some would argue that institutionalization remains the best possible option for elders in a fast paced industrializing society, it is necessary to note that much work needs to be done in order to reduce the incidence of poverty and improve on wellbeing of elders institution's in Nigeria.

RECOMMENDATIONS

In order to improve their wellbeing, the following recommendations are made:

- There should be comprehensive and consistent policies effectively formulated and implemented to enhance the general welfare of the elderly



- There is need for carrying out health and nutrition assessments and providing extra food to those at risk.
- Efficient, effective and qualified personnel who are well trained in the field of gerontology especially social workers should be further deployed to institutions housing the elderly for better performance and care.
- Visitation of children or other relatives to their institutionalized elders should be made compulsory to reduce depression.
- More comfortable and equipped homes should be built to cater for the needs of the elderly all over Nigeria.
- Residence in old age institutions should be made free or alternatively extremely affordable.
- The federal government should champion the cause of the elderly setting a pace for state governments to follow in Nigeria.



REFERENCES

- Adamson J. and Schmade, A. 1956. Object Loss, Giving Up, and the Onset of Psychiatric Diseases. *Psychosomatic Medicine*, 27 557-576
- Aina, O. 2012. "Two Halves make a Whole: Gender at the Cross-roads of the Nigerian Development Agenda" *Inaugural lecture series 250 delivered at the Obafemi Awolowo University on 25th September, 2012.*
- Amanda H, and Mark G. 2002. Chronic Poverty and Older People in the Developing World. *Helpage International. CPRC Working Paper No. 10.* Pp 1 - 24
- Anderson, K. A., and Dabelko-Schoeny, H. I. 2010. Civic Engagement for Nursing Home Residents: A call for Social Work Action. *Journal of Gerontological Social Work*, 53, 270-282.
- Akinyemi, I..A and Akinlo, A. 2014. Unmet Needs for Care and Support for the Elderly in Nigeria: Gaps in Experiences and Expectations of the Aged in Ilesa, South-West Nigeria In *The Nigeria Journal of Sociology Special Edition on Ageing in Nigeria*, 12(1), 28-43
- Barrientos, A. 2000. Work, Retirement and Vulnerability of Older Persons in Latin America: What Are the Lessons for Pension Design?, 1 - 24
- Bernheim, B.D., A. Shleifer, and L.H. Summers. 1985. The Strategic Bequest Motive. *Journal of Political Economy* 93:1045-1076.
- Blau, P.M. 1964. *Exchange and Power in Social Life*. New York: Wiley.
- Bradburn, N. 1969. *The Structure of Psychological Well-Being*. Chicago: Aldine.
- Charles, S. and Carstensen, L . 2010 "Social and Emotional Aging" *Annual Review of Psychology* , 61, 383-409
- Christopher, J. 1999. Situating Psychological Well-Being: Exploring the Cultural Roots of its Theory and Research. *Journal of Counselling & Development*, 77, 141–152
- David Gordon. 2005. Indicators of Poverty and Hunger. *Expert Group Meeting on Youth Development Indicators United Nations Headquarters, New York 12th – 14th December 2005*
- Dodge, R., Daly, A., Huyton, J., and Sanders, L. 2012. The Challenge of Defining Wellbeing. *International Journal of Wellbeing*, 2(3), 222-235. doi:10.5502/ijw.v2i3.4
- Dowd, J.J. 1975. Aging as Exchange: A Preface to Theory. *Journal of Gerontology* 30:584-594.
- Eboiyehi 2008. Care and Support for the Aged among the Esan of Edo State Nigeria, *unpublished Ph.D thesis, Department of Sociology, University of Ibadan*
- Emerson, E. 1985. Evaluating the Impact of Deinstitutionalization on the Lives of Mentally Retarded People. *American Journal of Mental Deficiency*, 90(3), 277–288.
- Ejikeme, T.U, Ejikeme G.G, Badru F.A, Akwash F.B 2014 "Social Support and the Welfare of the Older Adults in Conflict in Nigeria" *The Nigeria Journal of Sociology Special Edition on Ageing in Nigeria* 12(1), 243-256
- Erving Goffman. 1957. On the Characteristics of Total Institutions. *A Paper Presented at the Symposium on Preventive and Social Psychiatry of the Walter Reed Institute.*
- Felce, D. and Perry, J. 1995. Quality of Life: Its Definition and Measurement. *Research in Developmental Disabilities*, 16(1), 51–74
- Friday A. Eboiyehi 2009. Care and Support for the Aged among the Esan of South Nigeria
- Grady, R. O. 1990. Older Women and Poverty. Graduate School of Social Works. Boston College



- Gureje, O., Kola L., Ebenezer A., and Benjamin O. 2008 "Determinants of Quality of life of Elderly Nigerian: Results from Ibadan Study of Ageing." *Africa Journal of Medical Sciences*, 37(3), 21-48
- Harris C. and Cole J. 1980. Working with Older People. The Social Work Skills Series.
- HelpAge International. 2008. Older People in Africa: A Forgotten Generation. www.helpage.org
- Hendricks, J. 1995. "Exchange Theory in Aging. " In G. Maddox Ed.). *The Encyclopedia of Aging* (2nd ed.). New York: Springer
- Hogan, D.P., D.J. Eggebeen, and C.C. Clogg. 1993. The Structure of Intergenerational Exchanges in American Families. *American Journal of Sociology* 98:1428-1458.
- Homans, G.C. 1961. *Social Behaviour: Its Elementary Forms*. New York: Harcourt Brace Jovanovich
- House, J.S., Landis, K.R., and Umberson, D. 1988. Social Relationships and Health. *Science*, 241, 540-545.
- Ibitoye O., Sanuade O., Adebowale A., Ayeni O., 2014. Psychological Wellbeing of the Elderly in Nigeria *The Nigeria Journal of Sociology Special Edition on Ageing in Nigeria* 12(1), 74-85
- Isiugo-Abanihe U.C. 2014 .The Demography and Sociology of Ageing: Implications for Nigeria. In *The Nigeria Journal of Sociology Special Edition on Ageing in Nigeria*, 12(1), 1 - 8
- Kasper, J. D. 1988. Aging Alone: Profiles and Projections. Baltimore, MD: The Common wealth Fund Commission on Elderly People Living Alone.
- Kato E. 1998. The Situation of Older People in Cambodia. *Help Age International Programme in Cambodia*.
- King, G. B. 1985. Social Security and the Changing Role of Women. In U.S. Senate, Special Committee on Aging, Fifty years of Social Security: Past achievements and Future Challenges (pp. 60-72). Washington, DC: U.S. Government Printing Office.
- Lefcourt H. (1973). The Function of the Illusion of Control and Freedom. *American Psychologist*, 28, 417-425
- Levy, B. R., and Leifheit-Limson, E. 2009. The Stereotype-Matching Effect: Greater Influence on Functioning. *Psychology and Aging*, 24, 230-233.
- Lloyd-Sherlock. 2000. Old Age and Poverty in Developing Countries: New Policy Challenges.
- Minkler M., Stone R. 1985. Introduction: A Socialist-Feminist Perspective to Aging. *Journal of Aging Studies*, 7, 59-73
- Minkler, M., and Stone, R. 1985. The feminization of poverty and older women. *The Gerontologist*, 25, 351-357.
- Ryff, C. D. 1989a. Happiness is Everything, Or Is It? Explorations on the Meaning of Psychological Well- Being. *Journal of Personality and Social Psychology*, 57, 1069–1081
- Sarah C. White. 2008. But what is Wellbeing: A Framework for Analysis in Social and Development Policies and Practice. Centre for Development Studies ESRC Research Group on Wellbeing in Developing Countries.
- Shin, D., and Johnson, D. 1978. Avowed Happiness As An Overall Assessment of the Quality of Life. *Social Indicators Research*, 5(1), 475–492.
- Smolensky, E., Danziger, S., and Gottschalk, P. 1988. The Declining Significance of Age in the United States: Trends in the Wellbeing of Children and the Elderly Since 1939. In J. L. Palmer Smeeding, and B. Torrey (Eds.), *The Vulnerable* (pp. 29-54). Washington, DC: The Urban Institute



- Stanislav V. 1972. Physical and Mental Health Effects of involuntary Relocation and Institutionalization on the Elderly. *American Journal of Public Health*.
- Sussman, M. Cates, J. and Smith, O. 1970. *Inheritance and the Family*. New York: Sage.
- Ting C.A.O, 2012 *The Impact of Modernity on family structure and function: A Study among Beijing, Hong Kong and Yunnan Families: A Thesis submitted in partial fulfilment of the requirements for the degree of DOCTOR OF Philosophy in Social Sciences (Sociology), Lingnan University*
- World Bank, 1994. *Averting the Old Age Crisis*. (Washington D.C.,)
- World Health Organization. 1997. *WHOQOL Measuring Quality of Life*. Geneva: World Health Organisation.
- World Health Organization 2002. "Abuse of Elderly" in *World Health Report on Violence and Health*. A Report of World Health Organization