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Health and Social Problems of Elderly People in Selected Areas of Ondo State, Nigeria

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Abstract: The percentages of Nigerians living up to the age of 52 and above have increased significantly and these elderly people had not been given attention by the existing health care system and they are faced with many health and social problems. They need to be helped to maintain their health. The study examined specific experiences, the feelings, the coping strategies of the elderly and determines the role of family members in their care. Eight hundred purposively selected elderly people through Snowballing technique from 9 randomly selected local government areas in the state whose ages range from 60-98 years formed the study population. A semi structured interview schedule comprises of 4 sections of 46 questions and was tested for validity and reliability using Test-Retest Method and coefficient of 0.82 was established. Data collections took 12 weeks and were analyzed. The result indicated that elderly people complained of fever, hypertension, gastrointestinal disorders and generalized pains as well as vision problems and social constraints such as limited opportunities, neglects, loneliness, frustration and harassment. It was also found that highly educated elderly people reported better health. Elderly people in polygamous marriage had better psychosocial support than those in monogamous marriage. Furthermore, elderly people who earned higher income had improved health status. The health and social status of elderly people was mostly affected by income, age, familiar care coupled with social support and some varying degrees of common ailments being experienced by them. Hence, government and private spirited individuals need to create programs for the elderly wellbeing.

Key words: Health status, elderly people, social experience, social demographic condition, loneliness

INTRODUCTION

In recent times, the percentages of Nigerians living up to the age of 52 and above have increased significantly. The current estimate of elderly 60 years and above is about 6% of the population and it is expected to be greater than this in subsequent years (Fajemilehin, 2009). In <5 years from now, the number of the elderly growing beyond 60 years of age may be very close to about 15% of the total population. It is of paramount importance that these groups of people are not neglected. They need to be helped to maintain their health and independent life where possible.

Longevity is a product of several bio socio-cultural factors (Fajemilehim, 2000; Fajemilehin, 2009). As people get older, one of the greatest challenges in health policy is to strike balance among supports for self-care, informal support and formal care (Fajemilehin, 2009). They naturally show down and some even become incapacitated. Others may become self-centered and demanding, perhaps without realizing it. In times of needs close family members should be the first to help elderly ones. In a society where illiteracy poor nutrition low status of women and regular exposure to environmental hazards exist with political stability, feud and harsh economic conditions of the nation, it is interesting to still find elderly persons aged 60 years and above (Fajemilehin *et al*., 2007).

Hitherto, these elderly people had not been given attention by the existing health care system. There had been no serious attempts to elucidate the nature and variety of needs of this important segment of the population despite the fact that health care practitioners are aware of the problems of the elderly, they tend to give very low priorities to the care of the aged.

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Therefore, this study is planned to fill some of the existing gaps in the knowledge relative to the types of health and social problems afflicting the elderly.

Objectives: The objectives of the study were to:

- Assess the health status and social problems as well as coping strategies of the elderly people within the selected local government areas
- Examine the cultural influences and attitude of the society to elderly people
- Determine the roles of family members in the care of the elderly

Significance of the study: The study provided knowledge about the health and social problems of elderly people in Ondo State.

The knowledge and experience of psychosocial, cultural, economic and nursing had led to the development of interest shown for this study. It is hoped that the findings of the study would serve as an instrument of enlightening the family member and the society at large concerning their attitude towards the studied population and it would assist the social workers, nurses and government to understand special needs of the elderly.

Hypotheses:

- There will be no significant difference in number of elderly persons in monogamous and polygamous marriage who received adequate psychosocial support
- Educational status of elderly people will determine the health status of majority of them
- The health status of majority of the elderly people will vary with their level of psychosocial support
- The health status of majority of the elderly people will vary with their level of income (finance)
- Easy accessible to nursing care will affect the level of psychosocial support of majority of elderly people

MATERIALS AND METHODS

The setting: The study areas comprised nine randomly selected local government areas in all the nine dialectical groups in the state out of 8 local governments of Ondo State, Nigeria were selected for the study. The 9 local governments selected were Akoko North West, Akoko South West, Qwo, Akure North, Ondo East, Idanre, Odigbo, Ilaje and Lrele Local Government. Ondo State is located in the South Western Nigeria with a population of 2,850,230, the people of the state were selected for the study because of its numerous cultural orientations and a very significant numbers of elderly people with outstanding wealth of experience.

Target population: The target populations in this study are the elderly people in Ondo State with age 60 years and above irrespective of their level of education.

Design and participants: The study was a survey. The participants were 800 elderly purposively selected through snow balling technique from 9 randomly selected local governments whose ages averaged 72.67 years with a range of 60-98 years formed the study population. The 435 (54.4%) of the respondents were in polygamous marriage. The 365 (45.6%) were in monogamous marriage, 616 (77%) were Christians while 90 (1 l.3%) of them were self-employed. The 330 (41.3%) of the respondents had no formal education, 299 (37.4%) had primary education, 122 (15.3%) had secondary education and the rest 49 (6.1%) had higher education. Majority of the respondents 532 (66.5%) were farmers. There were 800 respondents of which 383 (47.9%) were male and 417 (52.1%) were females. The 573 (71.6%) were married, 201 (25.1%) were widowed while 26 (3.3%) were divorced.

Instrument: A semi-structured interview schedule comprises of four sections: A to D consisted of forty six questions all together was used to evaluate the questions raised m the statement of the problems, objectives and hypotheses. The interview schedule was tested for validity and reliability using Test and Retest Method and test-retest co-efficient of 0.82 was established.

Ethical consideration: Permission was obtained from the chiefs and head of household and consent of the respondents and their significant others was obtained and confidentiality was assured before embarking on data collection. The interview day and time was dictated by each respondent through the family head.

Procedure: Purposive and Snowballing approaches were used to select the subjects for the study through the chiefs within the community and the elderly people confident were used as the first point of contact in the community who introduced the researches to the respondent which enhanced high response rate and cooperation.

One hundred elderly people per local government selected were used. The elderly people used were selected through random sampling by casting of lots and the same method was used to select the villages/towns selected per local government where these elderly people were

selected. Quarters and streets were used in some of the local governments like Ondo and Akure where a town is a local government. A total of eight hundred elderly people were interviewed. Data collection took 13 weeks, the interview date and time was dictated by each respondent and the elderly people were interviewed separately. Each interview session lasted between 10-20 min with an average of 15 min.

Data analysis: Data collected were analyzed using descriptive and inferential statistics.

RESULTS AND DISCUSSION

The common health problems of the respondents include heart related problem/hypertension (9.7%), backache and generalized pains (17.7%), gastro-intestinal problems (15.4%), fever (126%), arthritis (115%), skin diseases (6.8%) and hearing impairment (6.5%). The skin diseases, diarrhea and indigestion might be as a result of the unhygienic feeding and living conditions of the elderly (Table 1).

The heart related problems might have caused swellings on the legs among the elderly people. In addition, the prostate problem might have caused the urine incontinence in few of them.

Table 2 showed that about 8.6% of the respondents had abnormal blood pressure assessments while the rest had normal blood pressure within the normal rate.

Table 3 revealed that about ha1f (51.5%) of the respondents had an abnormal visual acuity assessment. The type and frequency of psychosocial complaints of the elderly were also assessed. Table 4 revealed that the elderly complained of psychosocial problems such as death of close partners (22.3%), less social freedom (14.0%), poor social support (10.5%), limited opportunity (8.3%) and single parenthood (6.5%).

Table 5 revealed that respondents were divergent in their option and consistent to the extent that not <34% gave nurses and medical practitioners a pass mark for their sufficient on the elderly. The 177 (22.1%) of the respondents criticized nurses and medical practitioners over their carefree disposition to the welfare of the elderly.

To test whether the psychosocial support received by the elderly people could be categorized in terms of types of marriage.

Hypothesis 1 was confirmed by this result because 374 (46.75%) of the elderly people in the polygamous family had good psychosocial support (Table 6).

Apart from accessibility to health care, conventional education could also determine the health status of the elderly people. A Pearson χ^2-test was used to assess

Table 1: Common health complaints of the elderly

Ailments	Frequency	Percentage
Fever	132	12.6
Backache/Generalized pains	186	17.7
Arthritis	121	11.5
Hypertension/Heart related problems	201	19.7
Diabetes	32	3.1
Prostate/Urinary tract problem	47	4.5
Hearing impairment	68	6.5
Gastro intestinal problems indigestion	161	15.4
Chewing problem/Difficulty in swallowing	88	2.2
Skin disease	72	6.8
Total	1048	100.0

Table 2: Frequency and percentage distribution of blood pressure of the respondents in mm/Hg

Blood pressure value	Frequency	Percentage
Below 100/60	26	3.2
100/60-110/60	249	31.1
110/70-120/70	262	32.8
120/80-130/80	114	14.2
130/90-140/90	81	10.1
Above 140/90	68	8.6
Total	800	100.0

Table 3: Frequency and percentage distribution of visual acuity of respondents

Visual acuity value	Frequency	Percentage
16/36	27	3.4
6/24	163	20.4
6/18	198	24.7
Below 6/18	412	51.5
Total	800	100.0

Table 4: Psychosocial complaints of elderly people

Psychosocial complaints	Frequency	Percentage
Poor social support	135	10.5
Death of close partner	286	22.3
Single parenthood	83	6.5
Harassment from youth	135	10.7
Boredom/Loneliness	94	7.3
Poverty/Idleness	71	5.5
Less social freedom	179	14.0
Limited opportunity	106	8.3
Neglect	83	6.5
Frustration	110	8.4
Total	1282	100.0

Table 5: Respondents assessment of nurses in terms of their needs

Psychosocial complaints	Frequency	Percentage
Cared with much attention	272	34.0
Cared with fair attention	134	16.8
Carefree/Careless about	177	22.1
No attention at all	217	27.1
Total	800	100.0

Table 6: Summary of Chi-square showing type of marriage and psychosocial support of elderly people

Categories	f	%	df	χ^2	p-value
Monogamy poor psychosocial support	192	24.0	-	-	-
Monogamy/Fair psychosocial support	103	12.9	-	-	-
Monogamy/Good psychosocial support	70	8.8	2	363.08	<0.001
Polygamy/Poor psychosocial support	28	3.5	-	-	-
Polygamy/Fair psychosocial support	33	4.1	-	-	-
Polygamy/Good psychosocial support	374	46.8	-	-	-

Table 7: Summary of Chi-square showing status

Categories	f	%	df	χ^2	p-value
At most primary education/Poor health	362	45.3	-	-	-
At most primary education/Fair health	184	23.0	-	-	-
At most primary health/Good health	83	10.4	2	357.24	<0.001
At least secondary education/Poor health	12	1.5	-	-	-
At least secondary education/Fair health	10	1.2	-	-	-
At least secondary education/Good health	149	18.6	-	-	-

Table 8: Summary of Chi-square showing health status and psychosocial support

Categories	f	%	df	χ^2	p-value
Poor health/Poor psychosocial support	181	22.6	-	-	-
Poor health/Fair psychosocial support	52	6.5	-	-	-
Poor health/Good psychosocial support	34	4.2	2	342.15	<0.001
Good health/Poor psychosocial support	52	6.5	-	-	-
Good health/Fair psychosocial support	71	8.9	-	-	-
good health good psychosocial support	410	51.3	-	-	-

Table 9: Summary of Chi-square showing income and health status

Categories	f	%	df	χ^2	p-value
Low income/Poor health	500	62.5	-	-	-
Low income/Fair health	70	8.8	-	-	-
Low income/Good health	38	4.8	2	310.27	<0.001
High income/Poor health	31	3.8	-	-	-
High income/Fair health	61	7.6	-	-	-
High income/Good health	100	12.5	-	-	-

whether the health status of the elderly people could be categorized in terms of how educated they were. Table 7 revealed that more 362 (45.13%) of the elderly people who did not had more than primary school education also had poor health status.

The result in Table 8 indicated that 410 (51.25%) of the elderly people who received good psychosocial support also experienced poor health. This result supports hypothesis 3.

To test whether income (finance) would determine the percentage of elderly person with good health status. The result is presented in Table 9. The 500 (62.5%) of the elderly people that earned low income had poor health status.

Elderly people complained of medical conditions such as fever, gastro-intestinal disorders, generalized pains, hypertension and other related heart diseases as well as series of psychosocial complaints such as limited opportunities, neglects, loneliness, isolations, labeling, harassment and frustration.

This study also revealed that majority of the respondents had minimal or no difficulty with physical functioning as they perform activities without or with some assistance, the study findings showed a contradiction to the findings of Palmore (1977) that 20% of those over 65 years in the United States are unable to engage in their major activities, this may be due to difference in the demographic and ecological setting.

Many elderly people do not like going for medical care in government hospitals, the preferred unorthodox and religious health care due to their beliefs, culture and some past experiences in the hospitals.

Backache forms a leading symptom among elderly in Ondo State, this can be attributed to the elderly unwillingness to divulge from previous occupation that are strenuous and require bending down such as farming and fetching of firewood as well as some elderly preferred working for so long some refuse to retire from action service.

Poor household condition among the respondent also indicated a need for housing programme for the elderly. If provision of walking aids and infrastructures and skilled personnel to train the elderly in the use of these aids. This corroborated Bhalla (1978) assertion that the aged are more physically helpless, economically independent or less capable of adjusting to new roles hence their likelihood of enjoying high status is very remote.

The study revealed that most of the respondents were suffering from social isolation despite the fact that they live within their husbands and wives or relations in the same household, many responded to feelings of boredom neglect and loneliness of either because of empty nest or because they are aged. This was supported by Fajemilehin *et al.* (2007) and UNESCO (1987) that most of the elderly present deplorable condition were secondary to youth unemployment and adult joblessness and that cultural traditions in Asia normally provided adequate and sympathetic support to the aged population but two types of old persons are particularly vulnerable, the first are those who have no children or close relation to care for them and secondly, those affected by migration either because they have moved or because their children have migrated away.

It was also found elderly people in polygamous marriage had better psychosocial support than those in monogamous marriage (χ^2 (2) = 363.08, $p<0.001$). The null hypothesis is rejected. This was supported by Fajemilehim (2000) and Fajemilehin (2009) that elderly persons continuously living with spouse (s) or any other familiar support are more likely to display positive health behaviour and in addition live longer. Aging group at the level of 60 years over be it working class or otherwise are faced with changing world globalization, post-modernization confusion amidst the collapse of early traditional farming system which kept elderly surrounded by many wives and children and close range marital relations.

In addition, researchers found that highly educated elderly people reported better health than less educated elderly (χ^2 (2) = 357.24, $p<0.001$). The hypothesis is accepted.

Table 10: Summary of Chi-square showing the influence of accessibility to nursing care on the elderly health status

Categories	f	%	df	χ^2	p-value
Strongly affects	587	73.4	-	-	-
Affects	146	18.3	-	-	-
Do not affect	33	4.1	3	1040.64	<0.001
Do not strongly affect	34	4.3	-	-	-

Similarly, elderly people who had psychosocial support and better health status were more than those without psychosocial support (χ^2 (2) = 342.15, p<0.001). The hypothesis is accepted. This was supported by Fajemilehin and Ade-Ademola that meaningful social relationships that provide a sense of security and opportunities for companionship and intimacy are important for the well-being of old people.

Furthermore, elderly people who earned higher income had improved health status than those with lower income (χ^2 (2) = 310.27, p<0.001). The hypothesis is accepted. This was supported by Fajemilehin (2009) that income certainly, the basic and most central issue for the elderly in any society that elderly have less money with which to purchase health care and prone to chronic illness. It is obviously complex, critical and intentioned with the large problems of poverty, welfare and discrimination. This will be a result and effect of economic obsoleteness secondary to decreased strength, activities of daily living and retirement.

It was reported that easy accessibility to nursing care strongly affected their health status (χ^2 (3) = 1040, p<0.0010). This was supported by Fajemilehin and Fabayo (1991) that majority of people are frightened when they are sick or ill and have to go to hospital hence patronage of modern health care institutions will be a later taught when all other approaches of care fail (Table 10).

Therefore, there is an indication for specially designed health services for the elderly this would improve provision of health services and drugs to the elderly.

Implication for nursing practice: Aged are faced with many challenges, it is the responsibility of nurses especially community health nurses to make an assessment of the elderly people in later life by taking into account both the individual and the setting in which the elderly person lives. Also, rapid growth in the size of elderly people population has prompted concerns about the negative effects of old age and the psychological effects that these posed on the aged population. More attention should be given the health care practitioners especially the nurses to the problems of the elderly by given priority on health education the people (masses) and family members on the needs for maximum support for the elderly and how to make them live a fulfilled life.

CONCLUSION

The health and social status of elderly people was mostly affected by income, age, familiar care coupled with social support and some varying degrees of common ailments being experienced by them. Hence, government, multinationals and private spirited individuals need to create programmes for the elderly in order to improve better care of elderly.

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