INSTITUTIONAL CARE PROVISIONS FOR THE ELDERLY IN SOUTHWESTERN NIGERIA

BY

Gbeminiyi Mujaheed ADEGBOLA
B.Sc (Ed) (Tasued), M.Ed (Ibadan)
Matric Number: 165867

A thesis in the Department of Adult Education
Submitted to the Faculty of Education, University of Ibadan
In partial fulfilment of the Requirements for the Award of
the degree of

DOCTOR OF PHILOSOPHY
of the
UNIVERSITY OF IBADAN

JANUARY, 2021

ABSTRACT

The upsurge in the number of the elderly, owing to the weakened traditional family system and younger generation's socio-economic quest, has brought about increase in the provisions of institutional care facilities, where elderly are catered for, in southwestern Nigeria. This trend, as against the African belief system, raises concern about the acceptability, quality and cost of care and capacities of such provisions. Previous studies have focused largely on different aspects of their needs such as nutrition, social security, life satisfaction, indigenous welfare and retirement challenges of the elderly with little attention paid to the increase in institutional care provisions. This study, therefore, was designed to investigate institutional care provisions for the elderly in southwestern Nigeria in order to determine the motive, patronage, capacity, costs, care process, legal framework and predicting factors of its utilisation.

The study was premised on Activity, Ecological and Family Support theories, while the survey design was adopted. The three states (Lagos, Oyo and Ogun) with high numbers of institutional care facilities were purposively selected, while the 20 care facilities in the states were enumerated. Two hundred and sixty-four residents and outpatients with relatively fair cognitive ability and capacity to give consent were purposively selected. The instruments used were Institutional Care Provisions Questionnaire (r=0.74) and Institutional Care Facilities Inventory (r=0.73). Focus group discussions were held with the elderly, in-depth interviews with the professionals, and key-informant interviews were held with the family caregivers. Quantitative data were subjected to frequency counts, descriptive statistics and Logistic regression at 0.05 significant level, while qualitative data were content analysed.

Age of the elderly was 69.50±4.20 years with 32.0% as residents and 68.0% as outpatients, while 58.4% were female. Elderly who were married or co-habiting were 11.0% and constituted the outpatients. Private individuals motivated by profit-making owned 90.0% of the facilities, while patronage was based on personal conviction and individual's need. Most of the facilities (75.0%) were not built-on-purpose but converted to care facilities with structural deficiencies, while their existing capacities were: staff-resident ratio: 1:5.1; resident-room ratio: 1:8.3; resident-toilet ratio: 1:10.3 and less than 45.0% had call-bell facility. Average utilisation costs were: private - ₦100,000 and public - ₦50,000 for residence without medical expenses. Social, demographic and health status jointly predicted the use of the facilities (X^2=35.40; Nagelkerke R^2=0.33); accounting for 33.0% of its variance. Age (β=0.15), gender (β=1.95), marital status (β=0.99), functional disability (β=.09), cognitive disability (β=-.053) and depression (β=.17) relatively predicted facilities usage, while income, education and childlessness did not. Care process involved routinised, individualised and flexible patterns which accommodated the socio-cultural needs of residents. While there was no legal framework to specify minimum standard for residential care, there was an observed increase in the disposition and acceptability of the use of the facilities.

Geriatric institutional care provisions in southwestern Nigeria are increasingly becoming popular and acceptable with facilities' deficit and higher user fees without legal framework to specify minimum standard in southwestern Nigeria. Therefore, there is the need for basic minimum requirements for provision of residential care facilities.

Keywords: Geriatric institutional care provisions, The elderly in southwestern Nigeria, Residential care facilities

CERTIFICATION

I certify that this study was carried out by Gbeminiyi Mujaheed ADEGBOLA (Matric No.: 165867) for the award of the degree of DOCTOR OF PHILOSOPHY in Social Welfare under my supervision in the Department of Adult Education, Faculty of Education, University of Ibadan, Ibadan.

……

Deborah A. Egunyomi
B.Ed, M.Ed, Ph.D (Ibadan)
Professor, Department of Adult Education,
University of Ibadan, Ibadan.

DEDICATION

This work is dedicated to the teeming population of older persons who are struggling to make meaning out of life in their old age.

ACKNOWLEDGMENTS

All praises and adorations belong to Allah, the Lord of the worlds for His incomparable majesty and benevolence on mankind. I glorify His name for the mercies over my life and family and the grace to complete this work. He alone deserves to be worshiped.

I am grateful to my parents for everything; it is only God that can reward their efforts on me. I am equally indebted to my supervisor, Professor Deborah Egunyomi for her motherly support throughout the period of this work. My appreciation goes to all my teachers in the department among who are: Professors Aderinoye, Kester, Ojokheta, Abiona, Sarumi, Akintayo, Olajide, Adelore, Oladipo, Drs Odiaka, Oladeji, Omoregie, Omokhabi, Ojo, Taiwo and my god-mother Professor Momoh for all their supports, counsels and teachings, I am grateful!

My gratitude also goes to my mentors, relatives, friends, lovers and associates for their well-wishes, prayers and supports. To every other person that I have not mentioned, I did not in any way forget you and I hold you in a very high esteem. Thank you.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

The growing number of the elderly in Nigeria is becoming alarming (Togonu-Bickersteth, 2001; Kester, Adeyeye and Ogunyinka, 2007; Aikoje 2013). This is because the estimated population of the elderly (individuals above the age of 60 years) is about five per cent of the entire population of Nigeria (National Population Commission, 2009); and the population is growing at the rate of three percent per annum (National Bureau of Statistics, 2014). It has hitherto been projected that by year 2025, Nigeria will rank 11th among countries with over 15 million of the elderly population (Togonu-Bickesteth, 2001). In addition, the population of the elderly is projected to reach 16 million by 2030 and 47 million by 2060 (National Population Commission, 2004). This unprecedented rise, from the submission of Togonu-Bickersteth (2014) has brought about the concerned for survival and functional capacity of the elderly to live well in a country like Nigeria with no defined social security to cater for vulnerable group like the elderly. Consequently, because of economic and social occurrence, the increase in the number of the elderly has stressed the society's capacity in meeting their needs. Further, at old age, an individual becomes less active and depends on others in carrying out normal day-to-day activities of life because at this stage, individual becomes too weak physically and mentally to engage in social daily routine such as bathing and cooking at the level to which such an individual can cope. Thus, the elderly become dependents because of physical weakness occasioned by age; and such hinders their abilities to exert the required energy to live a normal functional life, without limited or prolong assistance.

Nigeria is gradually evolving policy and practice on the care and management of the elderly. The National Senior Citizen Act assented in 2018 was the first proper legislation on ageing, while institutional care for the elderly is also getting conscious attention. From the submission of Togonu-Bickersteth (2014), there has been a campaign by experts in the field of gerontology for improved mechanisms to address challenges of the old people in Nigeria, particularly those who have become vulnerable. Hitherto, the vulnerable conditions of these elderly people and the

resultant neglect they get from the Nigerian society, which is more evident in poor policy planning, and implementation, has continued to show the unfavourable disposition of the Nigerian State to the care of the older people. The National Population Policy in Nigeria has no provision for the elderly and as such no proper plan is made for this population group. The 2013 Demographic and Health Survey does not put into consideration the peculiarities of the elderly and the fact that, old age is not part of the demographic variables under the scope of the survey is inappropriate. Specialised geriatrics health care has been long absent in the country except for the recently established Geriatric Center at the University College Hospital, Ibadan. Recently however, there have been conscious efforts in Nigeria to establish institutional care for the elderly especially among the private investors. It is thus of particular relevance for policy planning and implementation to juxtapose significant evidences for emphasis on the provision of long-term institutional care for the elderly in Nigeria.

In Nigeria, care for the elderly is done traditionally in certain ways. Planning and preparation for old age in Nigeria differs in various forms and it is highly influenced by culture, tradition and prevailing government and private sector policies. For example, some people do invest in their children's education or save enough while working to care for their needs after retirement. This practice is popular in Nigeria since structural social welfare services for the elderly such as pension is not properly instituted. Whereas in other developed nations with structural policies and programmes for the elderly populace, a number of institutions are designed to care for the elderly which include old peoples' homes, hospices, and senior citizens centres owing to their increasing number, which is the consequence of successful medical breakthrough that has enabled people to live longer more than ever before.

Literature (Ajomale, 2007; Aikhoje, 2013; Togonu- Bickersteth, 2014) submit that culture demands in the Nigerian society that old people should be considered as part of the family and are expected to be taken care of by their children. Most of the very old people in the recent past lived with their children except for those who express strong preference for independent residence or who are very rich and comfortable. Others who do not live with their children lived within few distance away from one of their relatives. Members of different generations often visit one another and provide help in emergencies. However, as globalisation and

industrialisation increase, there is unprecedented rise in people's desire to get a white-collar job; every member of the family has been engaged in the formal sector one way or the other leaving no one to take care of the elderly. The social change and diffusion of western culture into the Nigerian society have made many children to prevent their parents from living with them, and since they have lesser time, the attention for their parents drastically reduces. Although moral and cultural influences continue to pressurise the children to take care of their parents, yet, social changes and industrialisation have made it increasingly difficult.

Deduction from the submission above identified traditional family system and pension as major arrangements of taking care of the social and economic needs of the elderly in Nigeria. However, from the report of National Institute of Ageing (2009) and Omotayo (2015), pension and traditional family system as arrangement for caring for the elderly in Nigeria are inadequate. This is because the prevailing condition has incapacitated the social and economic institutions and younger generation in their role to care adequately for the elderly. The implication of this is that a good number of the elderly with inadequate social and economic circumstances may also suffer health challenges and would practically become vulnerable to abuse.

Meanwhile, at old age, individual becomes vulnerable because of the unavoidable wear and tear of the body tissues and cells. Thus, precarious health challenges, susceptibility to chronic illness, social exclusion, bereavement due to loss of loved ones, financial incapacity among other factors expose the elderly to array of incapacities. Hence, with a large proportion of people getting into age 60 years and above, it becomes important to ensure functional living for these persons. This is because the challenges that come with old age particularly for people with precarious health challenges and functional problems with activities of daily living (ADL) and instrumental activities of daily living (IADL) would become enormous without help from either institutional care facilities or informal caring resources at their homes. Elderly people with these conditions have great difficulties in meeting their personal needs such as feeding, bathing, using toilet among others. Some may not have deteriorating health challenges but may not be able to carry out some activities such as flexible using of stirs which they have been used to before old age. Others may find it increasingly difficult to cope with dynamics of the society and prevalent social challenges. For instance, old people may find it continuously challenging to use

banking facilities in the light of the emerging digital activities that characterised the contemporary society.

Arising from the effects of these physiological and social changes, there is an evidence of growing number of institutional home care facilities for the elderly particularly in the South west Nigeria. These facilities were established to take care of the emerging need of the elderly people. However, the level of acceptability of the pattern of care in these facilities by the society is a cause for concern. Preliminary investigation revealed that most of these facilities might have been tailored after the western care prototype for the elderly, which may be alien and have significantly ignored the care needs of the residents. There is the need therefore, to better understand the issues relating to the provision of institutional care that is acceptable to Nigerian cultures as means of caring for the elderly.

A cursory observation of the institutional care provision in Nigeria revealed that as at 2007, there were only two facilities providing institutional support for the elderly in the southwest Nigeria. These are specifically located in Lagos. Surprisingly by 2017, the number of institutional care facilities in the southwest Nigeria has increased to about twenty which are privately established. This calls for concern on the reasons for the exponential increment in the rate of provision of these facilities. Ironically, continuous reports in literature posit that there is a cultural rejection of the institutional care for the elderly in the Nigerian society, yet provision of these facilities is on the increase. The trend of increment in the provision of the institutional care calls for empirical justification.

Scholars (Adelowo, 2000; Ajomale, 2007; Amaike, 2009; Salami, 2010; Egunyomi, 2012; Aikhoje, 2013; Omotayo, 2013 & 2015) have explored the deplorable conditions of the elderly, the societal neglect they experience and the suffering nature of the old people which become very apparent as huge number of them comb the street neglected, haggard and unsecured (Togonu-Bickersteth, 2014). Furthermore, the constant reports of precarious conditions of the old people in the national dailies largely due to the highly eroded social provision and weakened family system, has further brought concern for their capacity function in the society.

In addition, evidence in literature points to the fact that vast majority of the elderly in Nigeria previously express strong preference for living in their homes as

against institutional homes (Evbuoma, 2012). Paradoxically, there are positions favourable to the use of institutional care for the elderly even with the expression of preferences for living in their home. When an elder continues to have challenges of activities of daily living (ADL) and there is no member of the family that could provide informal care, hence there may be consideration for institutional care. The argument further, is that just as social and cultural demand has made dual earners family a reality for today's family and consequently the establishment of day care and crèche to care for infants, while their parents seek means of economic survival (Omotayo, 2015), so also the emanating condition may make old people's home a norm in Nigeria in the nearest future.

The World Health Organisation underscores the significance of institutional care to provide optimal wellbeing for the elderly. Institutional care provision has been identified to reduce the inappropriate of acute health services, help the families avoid the catastrophic care expenditures, and provide freedom for the informal caregiver (who are usually women) for more social roles (WHO, 2016). However, there is gap in knowledge on the indelible necessity for institutional care for the elderly and factors that may predispose the provision of institutional care for the elderly considering the socio-cultural values of the Nigerian society. Further, continuous reports of lack of optimal care for the elderly in the country which is characterised by precarious social exclusion and neglects, abandonments, discriminations against the elderly, stereotypes as a result of old age, challenges such as dementia, may account on one hand for the utilisation of institutional care facilities by the elderly and also sensitise stakeholders in gerontology to provide the care facilities with a view to alleviating the conditions of the elderly among other reasons.

Given the growing importance of institutional care for the elderly in southwest Nigeria, there is not enough literature on the provision of institutional care facilities based on our socio-cultural demand. There have also not been enough evidences for socio-cultural revolutions to justify the exponential increase in the provision of institutional care for the elderly and the complimentary utilisation that arises in the last few years. No doubt, understanding these would play significant roles in the domestication of institutional care for the elderly in Nigeria. Evidence in literature establishes the fact that institutional care for old people is rooted in the foreign culture and began in England (Townsend, 1962). Hence, despite the significant need for

institutional care facilities to optimize care for the elderly, which arises from the prevalent functional and cognitive incapacities experienced among the elderlyas well as the socio-cultural demand that drive the provision of the facilities; there may be a concern for structural adjustment of the foreign model of institutional care. Since research (Evbuoma, 2012; Togonu-Bickesteth, 2014) has proved prior to now, that vast majority of the elderly in Nigeria have expressed strong preferences for living in their homes as against institutional homes, and there is also a considerable increase in the number of institutional homes due to the arising need among the elderly, there is therefore the concern for issues surrounding the provision and delivery of the existing institutional home care for the elderly in southwestern Nigeria.

How the factors such as socio-cultural disposition, level of acceptability, institutional capacity, legal framework, cost and quality of care, care process, and utilisation influence or otherwise the institutional care facilities for older person is an important lead for policy consideration in the care and management of the elderly. It has therefore, become very important to understudy the need for organised means of (institutional) care for the elderly and the risk of dependent care, while considering the socio-cultural circumstances and factors that may be domesticated to better the care provision in the facilities.

Previous studies on the elderly in Nigeria have not focused on institutional care provision for older person. For instance, Wahab (2005) and Kester, Adeyeye and Ogunyinka (2007) focused on social and economic security of the elderly, Aboaba (2003) only focused on nutritional trends among the elderly, Aikhoje (2006) focused on life satisfaction among the retirees, Adedeji (2008) worked on indigenous welfare practices among the elderly in Nigeria and Ghana, and Temilola (2010) delved on poverty and wellbeing among the elderly. Similarly, Egunyomi (2012) x-rayed the situations of the elderly in Nigeria, Togonu-Bickesterth (1987, 1988, 2001 & 2014) worked extensively on the definition, preparation, problems and challenges of the elderly in Nigeria, while Omotayo (2010, 2012, 2014, 2015 & 2016) worked diversely on many issues concerning the elderly in Nigeria ranging from nutrition, sports, to economic viability, right denial, veneration, retirement challenges that are inextricable as a result of old age among others. Others have also focused on life satisfaction of the elderly (Amaike, 2006; Salami, 2010).

In addition, Evbuoma (2012) underscored the initiative of day care facility prototype as an alternative care for the elderly in Nigeria but lacks critical explanations for the predisposing factors to institutional care, the revolutionary changes and the expectant need of the elderly that may not be remedied by the day care initiative. There is an existing gap in literature therefore on the significance of institutional care facilities provisions particularly justifying the exponential increase in the provision as against the societal belief. None of the studies found in literature has focused on institutional care provisions for the elderly and factors that predispose them to the facilities in Nigeria. Therefore, this study becomes imperative and investigated the institutional care provisions for the elderly in southwestern Nigeria.

1.2 Statement of the problem

There is unprecedented increase in the number of the elderly in Nigeria, and this is likely to put pressure on the society's capacity to meet their needs. Hitherto, the traditional family system is an informal arrangement used to care for the elderly in Africa, but as civilization continue to evolve, the traditional family system has been weakened and fast eroded by the proliferation of nuclear family and dual earners syndrome, which is occasioned by the socio-economic quest of the younger generation. This has unequivocally brought about a growing interest in the establishment of institutional care for the elderly as evident in the exponential increase observed in the provisions of institutional care facilities for the elderly between 2007 and 2018 in the south west Nigeria as against the common position of societal rejection in literature. Whereas, whether the clog posed by societal concern on the usage of such facilities has weaned off is also a recurring issue to consider. Also, there may be issues of lack of concurrency in the legal provision for the establishment of institutional care facilities in Nigeria and providers of these facilities may supposedly adopt the foreign model of care which may not have put into consideration the socio-cultural needs of the users of these care facilities. This therefore raises the question of optimal care capacities of the facilities. There is also increasing concern for issues that bother on acceptability, quality of care, cost, and care capacities among other concerns for the provisions of institutional care for the elderly. Apparently, empirical evidences and positions in literature have failed to address these pertinent issues of institutional care provision for the elderly in southwest Nigeria. This study therefore examined the institutional care provisions for the elderly in southwestern Nigeria.

1.3 Objectives of the study

The major objective of the study is to examine the institutional care provision for the elderly in the southwest Nigeria. The specific objectives of the study are to:

i. examine the socio-cultural disposition and acceptability of institutional care provision for the elderly in the southwest Nigeria,
ii. assess the trend and motive for increased establishment of institutional care facilities for the elderly in the southwest Nigeria,
iii. examine the social, demographic and health factors predicting the usage of institutional care facilities by the elderly in the southwest Nigeria,
iv. ascertain the capacity of the existing institutional care facilities for the elderly in the southwest Nigeria,
v. examine the legal framework for the establishment of institutional care in the southwest Nigeria,
vi. determine the cost per unit of care in the existing institutional care for the elderly in the southwest Nigeria,
vii. examine the process and quality of care in the existing institutional care facilities for the elderly.

1.4 Research Questions

1. What is the socio-cultural disposition and acceptability of institutional care provision for the elderly in the southwest Nigeria?
2. What is the trend and motive for increased establishment of institutional care facilities for the elderly in the southwest Nigeria?
3. How do the social, demographic and health factors predict the usage of institutional care facilities by the elderly in southwest Nigeria?
4. What is the capacity of the existing institutional care facilities for the elderly in the southwest Nigeria?
5. What are the specifications of the legal framework for the establishment of institutional care in the southwest Nigeria?
6. What is the cost per unit of care in the existing institutional care for the elderly in the southwest Nigeria?
7. What is the process and quality of care in the existing institutional care facilities for the elderly in the southwest Nigeria?

1.5 Significance of the study

The study provided explanations on the socio-cultural dispositions of the elderly and their families on institutional care facilities provision with a view to examining the culturally acceptable framework for the provision. The findings of the research would influence policy and social action on issues concerning the elderly in general and particularly those that are concerned with institutional care. This is because it will provide relevant information for government and other interested groups towards giving attention to institutional care, which would improve the services delivery for the teeming population of the elderly and eventually improves the care to the elderly in general. The study, opened frontiers in the understanding of the determinants for the provision of the elderly' institutional care facilities and factors that predisposes the elderly to the usage of institutional care facilities in the southwest Nigeria. The study led the discussion on the resultants effect of individual level factors that may expose the elderly to institutional care and adduce justification for it while considering the cultural influence. It also brought to the fore the methods of care process used in addressing the challenges that hitherto bring the elderly to use institutional care. In addition, this study critically examined the need for the provision of institutional care facilities for the elderly, its justification and proper positioning to address the increasing need of the old people. The study, among others, provided empirical evidences and justification for more attention to institutional care for the elderly in Nigeria in both policies and practice.

Furthermore, with the growing interest in institutions that cater for the elderly such as old people's home which is evident in the recent concerted effort to increase the number of such institutions and the reality that the denial of institutionalization of old people by the culture is gradually weaning off, this study provided direction towards addressing the issue of optimal ageing through the understanding of the provisions of institutional care for the increasing number of the elderly. The study would help to develop model suitable for the provision of institutional care facilities for the elderly.

1.6 Scope of the study

The study focused on the institutional care provisions for the elderly in the southwest Nigeria. The study focused on the southwest Nigeria, because according to Omotayo (2012) and Togonu-Bickestert (2014) the southwest region has the highest

number of old peoples' homes in the country, and the level of consciousness of people in terms of education and exposure is relatively higher. The research was limited to Oyo, Ogun and Lagos states in the southwest, because they have higher numbers of institutional care facilities for the elderly. Elderly people who are 60 years and above and are users of the institutional care facilities in the southwest Nigeria either on day care or residential care were chosen for the study. These elderly were restricted to those who have not spent more than one year in the institutional care facilities because residents who have spent more than one year may likely have gone through psychological adjustment and adaptation to the care facilities (Einio, 2010) and may thus not able to view issues differently. Other criteria include the elderly with sound mind and relatively fair cognitive ability and capacity to consent.

Also, both government and privately-owned old peoples' home that provide residential and day care services for older person were included and special attention was given to trend of provision of institutional care between 2007 and 2018.

1.7 Operational Definition of Terms

The Elderly: Individuals above the age sixty (60) years who are residents or outpatients of institutional care facilities. It is also referred as the 'older person'.

Caregivers: Individual relatives or friends directly involved and responsible for the caring of the elderly.

Institutional Care Facility: A care home for old people where care (nursing and home care facilities) is rendered and living home arrangements are made for the elderly who may choose to be residents or access daily care. Health care may also be sparingly available but only when the need arises.

Care provider: The professional caregiver who provides services of care giving to the elderly in the institutional care facilities.

Institutional Care: Include the services that are available in the old peoples' home and contribute to older person's wellbeing. This include: social, spiritual, psychological, nutrition, health and accommodation.

Institutional Care Provisions: Provision of facilities that renders institutional care services for the elderly either on residential or day care.

CHAPTER TWO
LITERATURE REVIEW

2.1 Concept of Ageing

Ageing is generally referred to as process of growing old. It is commonly associated with changes in human physiology over a period of time. It encompasses the biological (physical), psychological and social changes in man. The biological aspect of ageing lays emphasis on how the passage of time affects the physiological composition of man, specifically the way older people exhibit physical changes such as body wrinkles and grey hair (Victor, 2005). Biological ageing is further attributed to environmental and social factors as though changes in the body structure may not exclusively be because of ageing. For instance, body wrinkles may be because of ageing, yet wrinkles may occur as a result of lifestyle and environmental factors such as sun exposure and smoking (Victor, 2005). Most biologists also refer biological ageing as senescence, which is described as decreases in efficient functioning of human body with age because of natural processes, which results into pathology and disease. This is further described as an involuntary phase in the development of human that results to reduction in adaptive capacity and ultimately death. Bowling (2005) conceptualised biological ageing as the 'progressive constriction of each organ's capacity to maintain the process by which the body reacts to changes when challenged, leading to reduced physiological adaptability, increased susceptibility and vulnerability to disease and eventually to death.' Ageing is further ascribed to cognitive and psychosocial impairments as ageing comes with deterioration in mental health, muscle strength cumulating in reduced levels of wellbeing and optimal life (Bowling, 2005). Hughes (2000) reported Bromley (1988) to have conceptualised human ageing 'as a complex, cumulative, time-related process of psychobiological deterioration occupying the post development phase of life'. This implies that human physiological composition continued to develop and deteriorate over a period of time related to biological, environmental and social factors. Ageing is therefore an intrinsically degenerative process, which is activated as soon as the body mechanism reaches the peak of functional capacity. Generally, biological ageing though has been given a universally acceptable definition, yet hypothetically, it is mostly accepted in

literature that ageing (biological) is characterized as essentially degenerative (Hughes, 2000; Bowling, 2005; Victor).

From the submission above, it can be deduced that ageing is a permanent biological change that takes place in all humans over a period of time. All human beings begin to age from their day of birth. The effect of ageing is very significant on human. Several changes occur in human physiology as it grows old; the organs that control hearing and vision begin to deteriorate, the muscle and tendons become weakened, body tissues like the skin and blood vessel become subtle and there is a general weakness in the body agility. The type of lifestyle established in earlier life often influences social and psychological concomitants of aging. Although writers such as Dytchwald (2005), and Bonsang, and Klein, (2011) have theorized that retirement is a disruptive life event. As people age, their ability to influence their environment is reduced by the changes in physiological and social-psychological make-up. Atchley (1999) suggests that as individual grows older; they are predisposed toward maintaining continuity in their habits, their manner of association and the preferences they established in their earlier years in life.

For long, research has linked ageing with, weakening, deterioration and disability. From literature, scholars such as Jason, (2009), Delcambre, (2011), Dychtwald, (2005) and Van Solinge and Henkens, (2010) are of the opinion that ageing involves the transformation of the human organisms, functions and structures resulting in gradual loss of psychological, biological, and behavioural capacities. In the sociological context, the concept of ageing is viewed at three levels: at the individual level of ageing experience, at the cultural level where social roles and norms are in focus, and lastly, at the societal level at which issues of the political economy of ageing is important. These levels are interrelated and defining ageing is manifested through the tension between the individual's capacity to make and re-make themselves and to resist the demands of social structure, and the ageing body (Jason, 2009).

According to Turner (1995), "*the crucial sociological issue in the ageing process is the contradictory relationship between the subjective sense of inner youthfulness and the exterior process of biological ageing*". In addition, individual ageing takes place within a generational or cohort context, certain generations may

have collective memories which are different from other generations. (Turner, 1995; Seitsamo, 2007). In other words, chronological age alone does not determine ageing.

The age at which an individual is considered or considers him/herself 'older' varies. According to Help Age International (2006), the ageing process is of course a biological reality which has its own dynamic, largely beyond human control. However, this also depends on the perspective by which each society conceives of old age. In the advanced countries, calendar time is considered to be paramount role. The age of 60 or 65, which is normally the retirement age in most countries, is usually considered to be the beginning of old age. As one ages, the process of engagement, disengagement, and re-engagement occurs as one redefines possible self and works toward goals, thereby increasing primary control. The effects of aging can be mitigated by disengaging from unattainable goals and redirecting resources to preserving well-being (Frazier, Newman, Jaccard and 2007). Sharma (2011) sees ageing as a universal phenomenon and the rate of growth of ageing population is increasing among the general population. Generally, persons above the age of 60 years are considered old enough and are thought as a burden to the society but with the intervention of many societies and intellectuals, they have been regarded as senior citizens. The population of these persons of the age of 60 years and above is fast growing in almost all countries of the world. These evidences in literature have given credence to the need to emphasize structural support for the older population. These underscores the importance of various caring means for the elderly for optimal wellbeing, such arrangement include Old people home, the fulcrum of this study.

2.1.1 Concept of the Elderly

Defining an elderly person could be cumbersome as there are no universally acceptable standard measures of who an elderly person is. Although the United Nations operationalised a working definition for an older person as an individual beyond the age of 60 which is synonymous to the elderly person, whereas this definition has been heavily criticised as there are no uniform standard of measuring life expectancy rate across countries and the measure of old age only on chronological calendar year does not equivalent to biological ageing as there are variations in the biological development of individuals (WHO, 2002). While giving an explicit definition of older person, Gorman (2000) argued that the ageing process is of course

a biological reality, which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases, it is the loss of roles accompanying physical decline, which is significant in defining old age. Thus, in contrast to the chronological milestones, which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible.

Most developed countries have generally accepted the chronological age of 65 years as the definition of an 'older person' (WHO, 2009). Apart from chronological age, defining the concept of old age could operationalised using the biological, psychological and socio-cultural processes. For instance, the social roles occupied by an individual could be a precursor to measure his age, the physical ability exhibited by the individual and the bias assessment of how old people feels (Barrett & Cantwell, 2007).

Lyons (2009) argued that literature has identified features predominant in defining old age through the appearances of physical characteristics such as body image, facial looks and hair colour. Other important criteria use in this definition includes mobility and mental alertness (Musaiger& D'Souza 2009). However, the use of chronological age in the definition of older person is not also uniform as there are wide variations from one place to another. A close study among elementary school students in the United States revealed that some respondents perceived an older person to be someone who is as young as 20 years, whereas others perceived an older person to be someone who is as old as 100 years (Hall &Batey, 2008).

The age of the perceiver has been identified as a factor that has considerable impact on the perceiver's understanding of when someone is defined as 'old'. Older people tend to judge the onset of old age to occur later in life than do younger people (Kimuna, Knox, &Zusman, 2005). For example, participants in a study by Musaigerand D'Souza (2009), aged 20-29 years considered 60-69 years as elderly, whereas participants over 50 years of age defined 80 years as elderly. The gender of both the perceiver and the perceived has been noted as a pertinent factor when

defining a person as old. Men are more likely to cite a younger chronological age as constituting ‘old age’ than women; and women are generally perceived by men to reach old age at a younger chronological age than men (Musaiger & D’Souza, 2009).

Historical perceptions and cultural norms have also been known to influence what constitutes being considered old. In the early nineteenth century, old age was considered to begin at 40 years, whereas in the last decade 65 years of age has been referred to as the upper end of middle age (McConatha, Hayta, Rieser-Danner, McConatha & Polat, 2004). This may be attributable to the steady increase in life expectancy. What constitutes being old can also vary between countries. For example, old age is considered to begin much earlier in Turkey than in North America and Germany where old age is perceived to start at a comparatively later chronological age (McConatha et al. 2004). These studies suggest that no consensus has been reached as to what constitutes being ‘old’. Factors such as physical appearance, age and gender of both the perceiver and the perceived as well as time and cultural differences all impact on whether or not a person is perceived as being ‘old’.

2.1.1.1 Elderly Persons in Africa

Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many westernized concepts, this does not adapt well to the situation in Africa. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion, but the UN agreed cut-off is 60 years and above to refer to the older population (WHO, 2002).Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous. The UN has not adopted a standard criterion, but generally use 60 years and above to refer to the older population.

Realistically, if a definition in Africa is to be developed, it should be either 50 or 55 years of age, but even this is somewhat arbitrary and introduces additional problems of data comparability across nations. The more traditional African definitions of an elder or 'elderly' person correlate with the chronological ages of 50

to 65 years, depending on the setting, the region and the country (WHO, 2002).

Adding to the difficulty of establishing a definition, actual birth dates are quite often unknown because many individuals in Africa do not have an official record of their birth date (Togonu-Bickerstet, 2014). In addition, chronological or "official" definitions of ageing can differ widely from traditional or community definitions of when a person is older. Following the position of WHO (2009), lacking an acceptable definition, in many instances, the age at which a person became eligible for statutory and occupational retirement pensions has become the default definition of old age. The ages of 60 and 65 years are often used, despite its arbitrary nature. Adding to the difficulty of establishing a definition, actual birth dates are quite often unknown because many individuals in Africa do not have an official record of their birth date. Age classifica1tion varied between countries and over time. Reflecting in many instances, the social class differences or functional ability related to the workforce, more often than not, was a reflection of the current political and economic situation. Many times, the definition is linked to the retirement age, which in some instances, was lower for women than men. This transition in livelihood became the basis for the definition of old age which occurred between the ages of 45 and 55 years for women and between the ages of 55 and 75 years for men, (Thane, 1978).

When attention was drawn to older populations in many developing countries, the definition of old age many times followed the same path as that in more developed countries, that is, the government sets the definition by stating a retirement age (WHO, 2002). Considering that a majority of old persons in sub-Saharan Africa live in rural areas and work outside the formal sector (Omotayo, 2015), and thus expect no formal retirement or retirement benefits, this imported logic seems quite illogical. Further, when this definition is applied to regions where relative life expectancy is much lower and size of older populations is much smaller, the utility of this definition becomes even more limited. Study results published in 1980 provides a basis for a definition of old age in developing countries (Glascock, 1980). This international anthropological study was conducted in the late 1970's and included multiple areas in Africa. Definitions fell into three main categories: (1) chronology, (2) change in social role (i.e. change in work patterns, adult status of children and menopause), and (3) change in capabilities (i.e. invalid status, senility and change in physical characteristics). Results from this cultural analysis of old age suggested that change in social role is the predominant means of defining old age. When the

preferred definition was chronological, it was most often accompanied by an additional definition. These results somewhat contradict the findings of a more recent study conducted in Nigeria regarding perceptions about the onset of old age. (Togonu-Bikersteth, 1987 & 1988) Younger and older age groups had similar responses regarding the chronological onset of old age, with differences in the stated age for men and women. The results suggested that the generally accepted definition was similar to westernized definitions of old age.

However, this was a unique community with culture-related norms that bestowed certain privileges and benefits at older ages. If one considers the self-definition of old age, that is, old people defining old age, as people enter older ages, it seems their self-definitions of old age become decreasingly multifaceted and increasingly related to health status (Freund, 1997). While a single definition, such as chronological age or social/cultural/functional markers, is commonly used by, amongst others, demographers, sociologists, anthropologists, economists and researchers, it seems more appropriate in Africa to use a combination of chronological, functional and social definitions.

2.1.1.2 Elderly Person in Nigeria

Elderly person in Nigeria is usually depicted with the retirement age of sixty-five. Though, most people sub-consciously accept anybody who is sixty years and above as an older person. Nigeria as a country has not done much to care for the elderly probably because the elderly are seen as part of the family and the reason for paying less attention to determining when an individual enters that category. However, with the increasing number of the elderly in the country, a number of steps were taken to care for them. According to Okunola (2002) in 1989, the National Social Development Policy and the Federal Constitution of Nigeria provided that the state should ensure policy towards the care of older person and there was provision to protect elderly against exploitation.

Historically, there were provisions in the Western state code to punish anyone who fail to provide or cause any negative consequence on the wellbeing of the elderly. In addition, the income tax Management Act of 1961 provides tax relief for workers in respect of the maintenance of close relatives like the elderly. Here, the government has tried to cushion the effect of caring for the elderly. Presently, as part

of universal provision, a number of states government have made the care of older person a priority, such include free health care services for people above the age of sixty years. In sum from the submission above, Nigeria as a country is concerned about the elderly and has put programme in place to care for them. However, the execution of this programme have been faced with a number of challenges such as the new pension scheme in which some state have failed to implement. A number of issues do affect older person in Nigeria, some of such are: social disengagement, poverty and culture.

In the first instance, an older person must disengage gradually from main stream of societal activities. The inevitability of ageing has made it compulsory for the elderly to gradually disengage from social activities. It involves formal disengagement such as retirement and informal setting such as from social gathering. At the age of 60 years, most if not all children of an elderly person would have left home in search of job or engage in marriage and started their own home thereby having less time for the aged parents. From the submission of Okunola (2002), the loss of spouse can mark the beginning of solitude and grief and the onset of depression, the intensity of which in some cultures is tempered by substitute spouse.

Secondly, poverty has been identified as a major problem of the elderly in Nigeria. This is because from the submission of various scholars such as Adelowo (2000) and International Institute of Ageing (2009), the main social support and economic safety net for the elderly such as the family and pension in caring for the elderly is inadequate. This is because majority of the elderly who have retired from active service owing to age and high level of unemployment find it difficult to get paid employment. Furthermore, changes in the structure of the family, such as dual earners family and children leaving home once matured to look for job or start own family since the onset of industrialization and urbanization has incapacitated the family from caring for the elderly. Besides, most elderly people in Nigeria have not worked in the formal sector thus are not eligible to pension. Though in Nigeria, some elderly do have congenial job or investment in stock, while some invested in their children education, that when the children become successful professional in chosen fields of professions will care for them, upon such proceeds and earnings some elderly people in Nigeria meet their basic needs. Finally, the frailty of the elderly has

naturally incapacitated them from employment and with poor runs of the economy in Nigeria, poverty of the elderly has exasperated.

Finally, in terms of culture, traditionally, the elderly is held in high esteem within the African society in which Nigeria is not an exception. Also, they are respected in public and private life. However, owing to cultural syncretism and exposure to foreign culture through the print and electronic media has eroded the respect the elderly used to enjoy. Every facet of life is affected and depict decline in respect of what elderly used to enjoy before. For example, the mode of greeting has changed, now it is not compulsory for a young adult to prostrate when greeting an elderly person. From the perspective of Okunola (2002), the perversion of highly cultural values with the introduction of obscene dresses, songs and dance indicate lack of respect for the elderly that are against such practices. The economic and social status of the elderly have weaned because there is an erosion of their political, social and economic relevance in our contemporary society.

2.1.2 Concept of Gerontology in Social welfare

The foundation of organized social welfare system is rooted in English Poor Law. According to Johnson, Schwartz and Tattle (1997), the British Parliament passed the law to regulate begging which brings the concept of welfare involve the government having observed the high prevalence of inadequate needs among the people. This concept proposes and emphasized the need for local community to care for poor people. From this premise, it can be argued that the poor law was the premier legislation that makes the issue of care of the needy an official concern of government. Owing to the fact that human needs are diverse and challenges are also diverse, there exists in social welfare, a field of gerontology that particularly focused on the social care and management of the elderly which is the thrust of this study. This study, which focus on provision and utilization of institutional care for the elderly, hinges on scholarly positions of Wilsenky and Lebeaux (1958) that identified residual and institutional care as two orientations in the field of social welfare that cater for the needs of the elderly.

The residual approach offers assistance whenever there is disruption in the societal arrangement through which people meet their needs. It can be as a result of human and natural disaster such as war and flood respectively. In such circumstance social welfare assistance that is done to meet needs of victim in emergency situation is

the residual approach as such is the case of Internally Displaced People (IDP) in North East, Nigeria owing to *Boko-Haram* insurgency. Provision is directed at basic daily essential needs for human existence: security, food. From the submission above it can be argued that residual approach is usually impromptu and brief which is designed for immediate rehabilitation of victims of unfortunate incidence within the society.

However, the institutional approach is more enduring and permanent in nature. It is a long-time approach which is used to address emergence and enduring permanent situation resulting from natural and human disaster. It concerns assisting individuals or group of people to attain satisfying standard of living (Omotayo, 2015). It is an all-encompassing assistance that cut across all human needs; though basic needs are essential, but institutional approach in social welfare concerns more with high class needs of ensuring functional living for life satisfaction. It provides specifics help for individuals in relation to needs which are beyond the pecuniary need of basic necessity such as security, food and shelter as obtained in residual approach.

Social welfare services, in relation to the elderly is the basis of social gerontology which is the care for individuals that are above the age of sixty whose increasing number according to Omotayo (2005) is an emergency. Owing to increasing number of the elderly and the fact that traditional means of caring for the elderly within the family system has weaned owing to industrialization, it becomes imperative to seek means of caring for the elderly that is more formal and official. Meanwhile, professionalism of individuals working with the elderly started in 1945 in the United State. A number of international engagement such as Vienna conference in 1982 and Madrid International Plan of Action on Ageing by United Nation in 2002 attest to this assertion that the elderly are important population group. In social welfare a number of means have been identified to meet the needs of the elderly.

2.1.2.1 Identified Means of Meeting the Elderly Needs

Before the twentieth century, very few people lived to be as old as many people today. This is because the number of the elderly was small and they are generally cared for by the family except for the institutional care provided by some private groups. However, the increasing number of the elderly has necessitated the

need to explore more advance means of caring for the elderly. Johnson, Schwartz and Tate (1997) have identified six major means of meeting needs of the elderly.

(A) Mutual Aid

It simply refers to the indigenous means of caring for the elderly within the family system such as it is obtained in Africa before the advent of colonialism. Here, the family support is strong and the elderly live within the household, cared for and depend on relatives for daily care. This has weaned with the advent of industrialization and old people home will probable become a norm (Omotayo, 2006). Encouraging family support for older person has been legislated by many countries to encourage citizens to take care of their elderly. Some countries have made tax reductions as incentives to individuals who have an elderly person to cater for. Others (China for instance) have declared lack of visit and abandonment of financial needs of aged parent, illegal (Adewale, 2015).

(B) Charity Philanthropy

The concept of charity philanthropy has to do with privatization of care of the elderly on the needs that are not pecuniary. This may involve an organization such as faith base organization setting up homes to care for old people. It can also be recreational in which day care centres are set up. For example, as reported by Aybonkhere (2016), the Alake of Egba land intended to give land for day care centres for the elderly in Egbaland. Such effort falls under the ambit of charity philanthropy in gerontological studies.

(C) Public Welfare

The concept of public welfare is an example of official means of caring for the elderly. It has to do with documentation and it does not involve family inclination; and social factors such as heritage, religion and ethnicity are not criteria for care. It is universal, open ended means of care in which the elderly are institutionalized. It is an arrangement in which the elderly are cared for in a facility with full complement of provision such as food, clothe, shelter and other essential facilities.

(D) Social Insurance

The annuity scheme, a non-contributory pension scheme in Nigeria is an example of social insurance of caring for the elderly especially those that have retired.

The insurance policy covered public and private sector workers. From gathered report, it is a programmed that terminates at death.

(E) Social Services

In respect to the elderly, social services relate to intangible services such as assistance that is devoid of monetary commitment. The major thrust is to ensure that the elderly function appropriately within the society. This is because not all help is financially solved. The major focus here is to increase independence of the elderly on others. It includes home delivery services and community support such as taking turn by youth in a community by assisting the elderly with house chores. From deduction into the submission of Omotayo (2012), social service is a form of care for the elderly that promote African culture.

(F) Universal Provision

From forage into literature, the concept of universal provision is a blanket cover for the elderly care. The main criterion for eligibility is the issues of age owing to the fact that there are some needs that are peculiar to old age. It includes recreation and day care services to address boredom. This is because family structure has changed as there are fewer young individuals to care for the elderly within the family. Thus, it becomes imperative for other means of caring for the elderly in which universal provision is one. The six arrangements are identified means of caring for the elderly that will ensure care and functional living for the elderly. Though, the means of caring for the elderly continue to evolve. Finally, they are not exclusive as they over lap one another because more than one of these means can be used at a time in meeting needs of the elderly.

2.1.3 Care of the Elderly

The 2002 Madrid International Plan of Action on Ageing emphasized the care of the elderly and support for the care givers to the elderly as an important mechanism for sustainability of the elderly across the world. It identifies that in most developing nations particularly in Africa, provision of care for the older person is mostly done by the family. However, family care without support and compensation to the caregivers is creating new economic and social burden. For instance, the responsibility of care for members of the family usually falls on the women, who routinely provide informal care for the vulnerable members of the family, particularly, the elderly. These women

bear the economic penalty of having to earn more money during the care giving because of absence from their places of work. The burden of emotional stress and physical activities also fall on them arising from balancing the work and household obligations. The anticipated plan of actions to ameliorate the challenges combating the elderly call for the establishment and amplification of human resources in health and social infrastructures which are imperative for the effective delivery of prevention, treatment, care and support services and reinforced by public policies as the proportion of the elderly increases.

Scholars (Ajomale, 2006; Evbuoma, 2012; Egunyomi, 2012; Togonu-Bickesteth, 2014 and Omotayo, 2015) have canvassed for community care and strengthening of family system for the care of the elderly but the emerging socioeconomic pressure has made it increasingly difficult. Despite the fact that the family members will have to take care of the financial demands of the older person, the physical, social and emotional care for the elderly can be overburdened. Also, community care is becoming practically unachievable as the coherence relationship that used to exist between and among the extended family compounds in African settings is weaning off. Even when the community coordination of care exists, they often lack sufficient capacity due to poor resources (UN, 2003). As a result, institutional care may be the preferred option of either the vulnerable and frail older person or the care giver. In view of the foregoing therefore, a range of care options which should be affordable, for family and institutions, would be appropriate. Eventually, the choice of the elderly in the assessment of their personal needs and scrutinize service delivery is essential to the preference of the most effective option (UN, 2003).

To achieve maximum care for the older person, formal care in the institutional setting is mostly expedient. Care is mostly administered by professional care givers such as Nurses and Social Workers carefully trained for the purpose. This is because the elderly are not a homogenous group as each person would have unique health needs, concern and personal circumstances reflecting the individual's personal history. The aim of all care is to help the older person maintain his or her health and independence as far as this is realistic and possible. This may mean regaining health and independence after an illness. People differ in the way they age, and older age

cannot be defined neatly at a certain year of life. Nevertheless, while it is difficult to define a person by their age, illness in later life has certain characteristics for all older people. In later years, people tend to suffer from more than one cause of ill health. Illnesses tend to be more difficult to diagnose, older people may deteriorate rapidly if untreated and have a higher incidence of complications. Disease in later life is vulnerable to adverse environments. Practical care needs should be directed towards active rehabilitation rather than just convalescence (Grimley, Franklin, Lynn, Michel, & Wilcock, 2000).

Grimley, Franklin, Lynn, Michel, and Wilcock, (2000) identified care objectives need as such to be set following assessment. These should reflect what the older person wants, and whether this is attainable, taking account both of the minimum requirements and of maximum achievements. Carers' views and available resources must be taken account of, and any necessary compromise needs to be negotiated. There should be a management plan involving carer about how care will be managed, taking account of what it will involve, when it should be done and by whom. It is also important to close the gap between the demands of the environment and the capabilities of the individual. This may be assisted by therapeutic interventions that improve function, such as lifestyle changes and medical treatments. Ageing brings with it a progressive loss of adaptability for the older person. There is a reduction in maximal performance as well as functional reserve. It requires more effort for the older person just to maintain his or her activities of daily living (often called ADLs) than it does for the younger person. The gap between what the person is able to do and what he or she has to do, just to keep functioning in daily life, narrows. Hence the older person needs to work at maintaining this functional capacity. Ideally, the older person should keep active in all daily activities of living such as shopping, cooking and washing in order to remain independent as far as this is possible. The practical need is to maintain a careful balance between promoting the older person's functional capacity and giving the person help when needed, even for a short time. If the older person does not use some capacities, for example as a result of illness, this may be recoverable initially but over time, disuse will become permanent (Grimley, et al., 2000).

Because convalescence after illness takes longer in the elderly than in younger people, early rehabilitation is vital, and needs to take into account the older person's

home environment. Rehabilitation is unlike convalescence because it involves more than just spontaneous recovery. Rehabilitation changes the natural history of recovery so that it takes time, skilled people and adequate equipment. There are needs to provide rapid responses to illness with a full medical investigation by the doctor. A social and functional assessment involves the nurse, occupational therapist, physiotherapist and social worker. The older person may also need swallowing and nutritional assessments by speech and language therapist and dietician, as well as assessment of sight, hearing and care of feet. Whether the older person experiences pain also needs to be considered, as this will affect movement and rehabilitation. Involvement of the multi-professional team is vital (Grimley, et al. 2000). Hence, assessment should consider the medical prognosis and physical and mental function, including health habits, vision, hearing, motivation and cognitive status. In assessing the older person's care needs at home, the physical environment and involvement of family and friends also require consideration (Caird and Grimley, 1995). They may play a very important role in keeping the older person as active as possible. Activities, both physical and mental, not only raise the morale and spirits of the older person, but it improves rehabilitation at every level.

Bradshaw and Merriman (2007) conceptualized the processes of caring for an older person into five basic categories while putting into consideration their needs for independent daily living and functional capacities. They categorized professional care for the elderly based on the need of the individual which include: 1, the elderly requiring assistance with personal cleansing; 2, the elderly requiring assistance with movement; 3, the elderly requiring assistance with eating and drinking; 4, the elderly requiring assistance with toileting needs; 5, Older person whose condition necessitates observation and monitoring; and 6, older person who is dying. They argued that caring for the elderly in the formal institutional setting requires standard procedures which must be followed, depending on each need of the individuals.

2.1.4 Concept of Institutional Care for the Elderly

Institutional care for the elderly can be provided through residential in-home services or day care centres. The type of care provided can range from assistance in dressing, bathing and ambulating to sophisticated medical life support systems (Gelfand, 1984). The uniqueness of institutional care facilities lies in their constraint on individual choice in everyday situations since the person living in these settings

must adjust to being removed from normal individual or family living patterns (Sibuh, 2015). Existing Institutional residences include chronic care hospitals, private and public nursing homes, old peoples' homes, psychiatric hospitals, and veteran's administration facilities. All of these facilities provide varied levels of care ranging from extended, skilled and intermediate care to personal and boarding care. Institutional care facilities are run under a variety of auspices including public, private/non-profit, or proprietary organizations (Sibuh, 2015).

The history of long term care institutions began with the almshouses and the public poor houses of colonial America (Gelfand, 1984). When a family or individual could no longer care for person, that person becomes the responsibility of the government. The disabled, aged, widowed, orphaned, feeble minded and deranged and victims of disasters were mixed together in almshouses, hospitals, workhouses, orphanages and prisons. Through time, almshouses became increasingly popular and in 1834, the poor law of England reaffirmed this approach (Sibuh, 2015). This philosophy of isolating the elderly from the society continued to be the predominant social policy throughout the nineteenth century. It is generally accepted that most old people prefer to live independently in their own homes (Vaarama, Pieper, and Sixsmith, 2008). However, institutional care in nursing or residential home is often the only option available for frail and dependent people, who require higher levels of support. From the deductions into Sibuh (2015) institutionalization should be considered when the elderly cannot get care from immediate or extended family that do not have other option other than to institutionalize them.

Care institutions provide adapted and safe environments and provide a range of care, such as support in everyday activities and medical procedures. In addition, to these instrumental issues, increasing attention is also paid to the general quality of life of residents through facilitating social participation, leisure activities and supporting residents' lifestyles, while trying to preserve individuals' autonomy and control. At the same time however, the individual has to conform to the social roles and rules prevalent in the institution. However, there is a contentious argument that utilization of institutional care among older people, can lead to "induced dependency" whereby the person undergoes psychological changes, loss of personal competence and even physical deterioration (Vaarama et al. 2008). Residents of care institutions facilities have serious limitations in their abilities to take care of themselves because of the

illnesses or frailties of advanced age. These conditions and associated functional decline inevitably have an impact on quality of life. As well as physical functioning, other factors such as psychological, social and emotional changes can have an impact on the elderly (Vaarama et al. 2008).

Institutional Care for the elderly in this study refers to all forms of special arrangement used to care for the elderly particularly those that focus on the psychosocial needs of the elderly which vary from country to country. In Denmark for example, a long-time care is adopted that promote home care and reduce institutionalization (Sibuh, 2015). An extensive social service, specially arranged for the elderly to stay in independent homes as long as possible and maintain an active life style to prevent them from going in to nursing homes or other institutions is planned. In this instance, well-coordinated medical, social and community care services are planned for the elderly. These services include home cleaning; shopping, cooking and personal hygiene. The major goal of the programme is to allow the elderly and their children to live independently. However, the frail elderly cannot remain at home but were taken to nursing home.

Another form of care for the elderly is hospice. According to Saunders (1980), the term refers to stranger or host. It originated in medieval Europe when the term was used to refer to settings that provide shelter for travellers and care for the ills, weary, dying and abandoned. From the idea of Hayslip and Leon (1992), the idea of hospice is to ameliorate difficulties surrounding death and strife to make life journey easier for those who are nearing its end. The goal is to allow the terminally ill to die easily and at peace without pain, in their own homes. The idea is to view death with dignity as an alternative to the coldly scientific, medical model of dying. The central concept of hospice is pain management. Here, terminal pain is considered an illness itself to be diagnosed and treated according to individual's needs. The major concern of hospice is avoidance of euthanasia and best treatment for terminal pain is prevention. The structure of hospice does vary. In the first instance, it can be home based care, often provided by groups of professionals and volunteers. Besides, it can be provided by health care agencies or visiting nursing associations. Thirdly, it can be free standing facilities, while it can also be hospice in special units of wards or hospitals that emphasize the relief of pain and suffering and finally hospice can be provided in nursing homes (Gold 1995).

Despite this variation, the service provision of hospice is similar. These include medically directed continuum of care and support for terminally ill patient and care of family members. It also includes counselling and respite support before the death of loved one and follow up bereavement care for up to a year. The services are integrated. It involves professionals like social workers, clergy, and medical personnel. In sum, the major concern of hospice is management of pain and not treatment of terminal disease.

According to Akeredolu -Ale and Aribiah(2002), old people's home is one of the means of caring for the elderly. According to Cowart and Quadagno(1995) nursing home is the long-time care of last resort for the elderly. According to Foner (1994), majority of Americans will spend some time in the nursing home and the essence of nursing home from the submission of Hardwick, Jennifer, Elizabeth and Aleske (1994) is based on the fact that some elderly people lack a support system that will allow them to remain at home. From countries where nursing homes are well established, a number of challenges are being faced by the occupants. From progressive monitored report from scholars and organisations such as; Harrington (1991), General Accounting Office (1995), and Quadagno (2002), poor quality care is a continuous problem in old peoples' home. In fact, according to monitored report, one third of nursing home in America were operating at substandard level. Identified problem include: untrained staff, poor health care, unsanitary condition, poor food and unenforced safety regulation level. Though *unafrican*, but it remains a source of care for the elderly in Nigeria. This is because social changes and peculiar evolution of the family structure over time has weakened the family as a social institution in caring for the elderly. While inflation and irregular payment of pension have declined, the family's ability to meet old people's needs, even if available, most of the elderly in Nigeria have not worked in the formal system so they are not eligible for pension.

From the position of Okunola (2002), institutionalization of the elderly is best promoted at local level. Preliminary observation revealed that in Nigeria most institutions for the elderly are managed by religious organization. The population in the homes is comparatively small and management is mainly from charity and token given by philanthropist. From the foregoing therefore, institutionalization of the elderly exist in Nigeria however *unafrican* the practice may be. Thus, it becomes imperative in the view of present realities to assess determinants of provision and

utilization and corresponding service delivery in institutional care facilities particularly old people's home in Nigeria.

2.1.4.1 Institutional Care Facilities for the Elderly in Southwest Nigeria

Institutional care facility in the south-western Nigeria is gradually growing. Institutions that provide residential and non-residential care in Nigeria have been traced to originate from the Catholic missionaries, for instance the Regina Mundi Home for the Elderly in Lagos and Pope John Paul II Good Samaritan Home for the Elderly in Calabar are some of the earliest to be established in the country. The missionaries were driven by charity goal to provide succour to the vulnerable. Also, the government has also been part of the providers of institutional care with reference to the Old Peoples' Home in Lagos and the recently established Tony Anenih Geriatric Center at the University College Hospital, Ibadan. Many private individuals have also during the last decade, established institutional care facilities for the elderly particularly in southwestern Nigeria. There are over twenty institutional care homes for the elderly in the Southwest Nigeria.

Table 2.1: Location of Institutional care facilities for the elderly in Southwest Nigeria

SN	STATE	NAME OF INSTITUTION	ADDRESS
1.	Lagos	1. The Old Peoples' Homes	Birrel Avenue, Yaba Lagos
		2. Regina Mundi Home for the Elderly	142/144 Agege Motor road, Mushin Lagos
		3. Winiseph Care Home	326, Adeyemo Akapo street, Ikeja Lagos
		4. Rockgarden Homes	191/193 Okeletu-ijede road, Elemu bus stop, Ikorodu, Lagos
		5. Wellcare Home	65, RasaqBalogun Street, off Adebola Street, off AdeniranOgunsanya street, Surulere, Lagos.
		6. Alpha Nursing agency	38, Oyewole Street, off shyllon street Ilupeju, Lagos
		7. Miradora Care Homes	24, Ibironke crescent, Maryland, Lagos
		8. Bluegate Care Agency	17, Morowofolu street Akoka, Lagos
		9. Beautiful Angels	13, Olasanoye street, Ijegun-Egba, Amuwo-Odofin, Lagos.
		10. Family Ark Mission Agency for the Aged	Family Ark Mission Center, Ikeja, Lagos.
		11. Regal Care Nig. Limited	57, Odozie Street, Ojodu, Lagos.
2.	Ogun	1. Pro-Laborde Elderly Home	Ijebu Ife
		2. Live on Old Peoples Home	Km 40, Lagos-Ibadan Express way, Maba, ObafemiOwode, Ogun State.
		3. Gideon Home for the Aged	31, Adegboyega street, Asero Housing Estate, Abeokuta.
3.	Oyo	1. Rossetti Care	Wahab Olayiwola layout, Tose Moniya, Ibadan
		2. Divine Senior Citizen	Palace PDCOS Estate, Akobo, Ibadan
		3. Emmanuel Alayande Rehabilitation Center	Awotunde Estate Elekuro, off OlorundeAaba road, Ibadan
		4. Vineyard of Grace Home Health Care Agency	24, Kudeti Avenue, Onireke, Ibadan, Oyo State.
		5. Tony Anenih Geriatric Center	University College Hospital, Ibadan.
		6. Assisted living Homecares Limited	36, Alaafin Avenue, Oluyole Estate, Ibadan.

Source: Preliminary survey, 2016

Most of these facilities were established within the last decade and accounted for the growing attention of stakeholders in the care and management of the elderly largely due to alarming need for their care for optimal functioning.

2.1.5 Socio-cultural disposition and Institutional care

As individual ages, the physical and mental development gradually becomes associated with the social structure, process and the cultural context of the society he belongs. The society shapes the sub-consciousness of the individual until death. He adopts the ethical values and beliefs, traditions, cultural dispositions. These influences of socio-cultural environment often informed the basis of handling situations of events at old age such as illness, cognitive frailty, death of a spouse, social interactions, and health related decisions such as institutionalised living. In making health decision for the old people, McPherson (1994) posited that practitioners and care givers must understand the culture, the social structure, and the demographic and social process associated with ageing in the specific social and cultural context. This implies that there must be clearer understanding of the individual level and the socio-cultural determinants of the institutional care usage. Ethnic and cultural groups differ in their commitment to the care of the elderly. Care provision for the elderly differs from one country to another, there has been a rapid change within the context of the same country, ethnical and local differences exist in respect to the care services delivered to the elderly (A Senior Companion, LLC 2009). The older person need care as their personal activities get limited by developmental challenges resulting with a degeneration of health, disability, frailty and incapacity for self-care (Levison, 2008). All these and many more call for decisions about where and with whom to live and this is influenced by cultural traditions and values.

Culture is commonly defined as the shared ideas, values, formations and uses of categories, assumptions about life. Hence, culture is expected to affect the daily organisation of institutional care because it leads people to categorise and assign meanings, expects certain behaviours and act in particular ways. In the United States for instance, minority groups are less likely to use skilled nursing facilities and perhaps more likely to tolerate dementia and old age disabilities at home (Whitehouse et al, 2005).

Older people constitute one of the most vulnerable parts of the society. They are not only physically weak but also lack self-esteem. At some points, they also lack economic resources and social status. Changes in the family size and the weakened traditional system which prevent adult children to live with their parents have resulted in plethora of emotional security problems for the old people which necessitate the changes and organised living arrangement that will factor the socio-cultural needs of the elderly and give them a replica, if not in total, of their socio-cultural values as an intervention necessary for their survival (Sandhu&Arora, 1999).

The elderly in each society have experiences they go through that are most likely not similar to what other fellow elders experience in other society or culture. Hence, studying the physical environment, social structure, cultural disposition, accessibility, companionship, and the general pattern of care in the existing institutional care for the elderly would reveal the socio-cultural situation of the elderly in those facilities and the expectation in the homes to meet their needs. Understanding the socio-cultural factors is necessary to prevent the surface of cultural nuance if a culturally congruent elderly care is not provided. Institutional care givers need to consider the nuances which are most likely to affect the health and status of the elderly (Yehieli**,** Grey**,** &Werff**,** 2004)

A key piece currently missing in the institutional care literature is the role of varying personal cultural beliefs and values on individual behaviour. It is assumed inadvertently that basic elements linked to ethnicity and culture may form health perceptions, attitudes and behaviours. It is thus important to acknowledge cultural diversity and study the specific cultural beliefs of each ethnic group as related to institutional care.

2.1.5.1 Acceptability and Institutional care facilities in Nigeria

Previous studies on care and condition of the elderly in Nigeria (Ajomale, 2007; Egunyomi, 2012; Evbuoma, 2012; Togonu-Bickesteth, 2014) have argued that old people's home is traditionally alien to Nigeria cultures. The acceptability of old people's home is gradually appreciating. According to Omotayo, (2009) old people's home is gradually becoming a part of Nigeria system as the effect of globalization and industrialization begin to pressure the primary care givers among the family members as a result of evidently economic demands. He argues that the cultural resistance to

old people's home will gradually wean off as the extended family structure collapses. This is very evident in the contemporary Nigerian society as people now find alternative care in old people's home for the care and management of their older ones. Omotayo premised his argument on the cultural changes and acceptability towards the crèche and day care centres for the infants. He posited that in the early 1980s, the Nigerian society frowns on the mother who drops the care and attention for her child to institutional care. But as the socioeconomic demand begins to pressure, the society gradually changes her perception towards this, which of course is gradually becoming apparent in the case of old peoples' home.

Preliminary investigation revealed that there has been geometric increase in interest in the establishment and provision of institutional care facilities for the elderly among stake holders. On a cursory count, there have been over twenty institutional care homes established in southwest Nigeria in the last decade. This revealed that there is either perceived or observed demand for the establishment or the pressuring precarious condition of the elderly as the case may be have necessitate the sudden outgrow of interest and establishment of institutional care facilities among the elderly. The structural changes in health care system and the incessant campaign among the specialists in geriatric which have continuously advocated for institutional care for the elderly have also contributed immensely to the outgrow and gradual acceptance of the elderly institutional care facilities in Nigeria. The World Health Organisation underscores the significance of institutional care to provide increased wellbeing for the elderly with significant decline in capacity, institutional care provision has been identified to reduce the inapt of acute health services, help the families avoid the terrible care expenses, and provide freedom for the care giver (who are mostly women) for more social roles (WHO, 2016). However, despite the significant impact institutional care may have on the elderly, there are evidence based empirical data that still suggest that there is a huge vacuum in the provision, access to and utilisation of institutional care services in many developing countries like Nigeria (WHO, 2016).

2.1.5.2 Quality of Care in Institutional Care Facilities

Several studies in the past have attempted to measure the quality of care in institutional care facilities. (e.g. Noelker & Harel, 2001; Harris, Piper & Morgan, 2003; Grundy & Jitlal, 2007). The focus of policy makers has been beamed towards the process and quality of care largely because institutional care settings are also considered as health facilities not only for the care roles but also for the attention they

pay to the health needs of residents. Donabedian (1980) postulated the measuring indices for quality of care and this places much emphasis on the structure of the facility, process of care used in the facility and outcome of care achieved on the residents in the facility. Structure is defined as the construction of the buildings in physical environment, the design and aesthetics that is expected of a home and the quality of staff in the facility. Process is defined as the appropriateness of care and how the care is carried out, what the care entails and when the care is done; these may include the protection of rights, proper functioning of residents, discharge of patients procedures, residents assessment, services required to maintain realisable functional ability and the handiness of enough professional staff at all times. Care results have been the pivot issue in monitoring the extent of care, the quality and process of care in the institutional care facilities largely because they constitute the indices of measuring the standard and regulation adherence. Instances of indices to determine standard results may include the incidence of pressure sores, suitability of tube feeding, frequency of falls, usage of restraints and occurrences of malnutrition among others (OECD, 2005). Meanwhile, deduction from Donabedian's framework on the quality and process of care failed to distinguish the entire factors determining the quality of life of residents.

2.1.5.3 Religion and Institutional care

Research (Chater& Tsai, 2008; Pocinlo, Belo, Antunes, & Rodrigues, 2016) has established that there is an enhancement of the effects that religious and spiritual dimension causes in individuals in order to achieve the intrinsic challenges in the aging process. Finding the patients' values, beliefs, religious and cultural needs are essential if the researcher wants to confirm the problem. Religiosity involves relationships with a community that shares beliefs and religious rituals. It is an organized system of beliefs, practices, rituals and symbols that facilitate the approach to the sacred and transcendent (Moreira-Almeida, Neto, & Koening; 2006). According to them, spirituality refers to assigning a meaning to life, the search for meaning and transcendence, and may or may not be connected to a system of religious beliefs. Quality of life at the end of life bonds some of the sorts of quality of life in older age which is important to retain a personal identity and a sense of self, in order to promote social contact and independence.

The relationship between religion/spirituality and health has become a clear paradigm to be established in the daily practice of health professionals; since religiosity and spirituality are strategies that older people use in their daily lives, to seek support in stressful situations related to one's finite nature, distance from family and their socioeconomic context, during the common health problems of daily life and their institutionalization.

Vitorino and Vianna (2012) conceptualises spiritual/religious *coping* as the process by which an individual, through her spirituality, belief or religious behaviour, attempts to understand and / or deal with important personal or situational challenges in her life. The presuppositions are: the existence of a stressful experience; assessment that the person makes about the situation – threat, harm or challenge; resources available to deal with stress, and responsibility in dealing with a particular experience. In addition, Pargament, Koenig and Perez (2000) posited that there is consistent evidence of an association between quality of life and religiosity/ spirituality. While analyzing the indices encountered in a study among older adults in Long term institutional care facilities in Brazil, Perez (2000) observed that the elderly felt comfortable in their use of religious/spiritual beliefs and behaviours, as a support in the resolution of their problems, and to prevent potential negative emotional consequences and stressors in their daily lives in the Long Term Care Facilities. They reported further that many of the elderly in Long Term Care Facilities have difficulty facing the institutionalization process, because of physical limitations, medication control and fear of relapse, remaining passive, limiting their self-care; delegating their state of health only to God and their beliefs. The competence of the elderly can be inhibited or stimulated, depending on the modality of Religious/Spirituality Coping practiced.

At the beginning of institutionalization, the elderly may go through acute changes in which their daily life is marked by a new routine with new rules, schedules, lack of flexibility, being quite different from the familiar environment (Bessa, Silva, Borges, Moraes, &Freitas; 2012). These factors potentiate the dissatisfaction with the institutionalization, making the adaptation process more difficult and, consequently, less use of religion and spirituality in coping strategies. However, with the passage of time and greater adaptation to the changes, with an increase in the bond with other elderly, professionals and a new autonomy, the elderly

of the Long-Term Care Facilities used more strategies of the religious and spirituality coping skills (Vitorino&Vianna; 2012).

It is believed that older people with more children use religious factor to positively address the process of institutionalization, because, in some way, they feel the lack of a family support network in the case of their children. The elderly who practised religion was reported to have a higher correlation with the positive factor *"personal search for spiritual growth"* and "*actions in pursuit of another institution*". These factors are associated with search and personal growth with God and the approximation of religious institutions and their leaders, respectively (Panzini & Bandeira, 2005). In religious practice, the elderly of the Long-Term Care Facilities develop their spiritualities and stronger links with the religious institution, favouring the coping practices (Vitorino &Vianna, 2012).

2.1.6 Provision of Institutional Care Facilities for the Elderly

Preliminary investigations revealed that the provision and utilisation of institutional care facilities in Nigeria is growing gradually. Deductions from Evbuoma (2012) indicate that there is growing interest in institutional care for the elderly; though such growth in the provision has been challenged by the poor cultural dispositions of the society. Yet, there have been continued increase in the provision of the institutional care facilities. Many reasons may therefore be adduced for this. The perceived need for institutional care alone could account for the major reasons for provision. As observed by literature (Egunyomi, 2012; Evbuoma, 2012; Togonu-Bickesthet, 2014 & Omotayo, 2015) the needs of the elderly can no longer be taken care by the conventional family system; and evidently, institutional care becomes very imperative to achieve optimal well-being for the growing number of the elderly. This perceived need observed in literature has further been substantiated with evidences of plethora health needs among the elderly and their susceptibility to become vulnerable owing to their lack of substantial access to the care required for optimal capacity which could only be provided through institutional care. Major reasons accounted for the provisions of institutional care facilities apart from the perceived need of the elderly, may be the growing interest in gerontology and geriatric, service provision for profit benefits, consolidated charity-philanthropic wave towards the elderly among others. Conversely, the determinants of the utilisation may also be a function of the

provision which for instance the government may be obliged to ameliorate. Meanwhile, the sudden rise in interest on the provision of the elderly' institutional care facilities majorly among the private individual and corporate bodies' call for concern of research to understand the causal objectives towards this move.

Complimentarily, understanding the determinants of utilisation of the elderly' institutional care may further account for the reasons of the provision. The presumption that old age brings about functional incapacities which interfere in the ability to cater for the activities of daily living (ADL) such as taking bath, preparing personal meal and using toilet, and sometimes cognitive incapacities which also impedes on instrumental activities of daily living (IADL) such as making independent decision may account for demographic and health related factors as proportionate determinants of utilisation and consequently provision. Similarly, the dual earners family syndrome, weakening of extended family structure and lack of proper care and attention for the elderly in the family may also be responsible for the decisions to use institutional care facilities that would provide adequate care for the elderly members of the family. This decision however, may come from family members whose burden of caring falls or those who feel obligated towards the care of the elderly unfortunately the elderly may be left with no option. Such demand from family members with burden of care for an older person, if it continues to increase by the day, may sprout the establishment of institutional care facility from a potential service provider.

2.1.6.1 Institutional capacity and institutional care facilities

The need; to pay specific attention to the design and components of the physical structure of the institutional care buildings; the available facilities in the structure and the pattern of care offered, is simply because they play major role on the well-being and health of the elderly which is a very key feature of their quality of life alongside that are usually given less attention and sometimes ignored. In essence, these are also dependant on the importance placed on the quality of care by the policy-makers through the legal framework to remediate deficiencies and set required benchmark standard for achieving quality of life in institutional care provisions. The implication of this, therefore, is the domestication of the socio-cultural values of thee residents into the pattern of care process and allow the elderly be involved in the decision, scope and nature of care administered to them. While studying the quality of life of the elderly in institutional care Murphy, O'shea, Cooney, Shiel, and Hodgins,

(2006) posited that the structures of physical facilities and the construct of the social environment have a vital role to play in the lives of the elderly in institutional care facilities. They may also have an indirect influence on other spheres of their lives. For instance, the facility offers environment or surroundings that can may or dampen the will of the residents from keeping current relationships or making new ones. Residents in most cases may have to rely on the structure of the physical design and structure of the institutional care facility to recompense for their disabilities in impaired mobility, loss of sensory ability or cognitive incapacity (Parker, Barnes, McKee, Morgan, Torrington, & Tregenza, 2004).

Einio (2010) reported in a study that the facility has a small but significant effect on the resident characteristics and influences the elderly pattern and quality of life. The study revealed that institutional care facilities can influence many aspects of lives of the elderly which include comfort, privacy, meaningful activities, security, and many more. The design and pattern of facilities in institutional care settings is important for optimal wellbeing of the elderly particularly those with certain health challenges. For example, residents who are suffering from dementia may gain a lot of benefits from an environment that is friendlier socially and have a semblance of homes with smaller units, have easy access to safe garden and relatively preserved space (O'Shea & O'Reilly, 1999).

A garden is a significant component of the physical environment in an institutional care facility because it provides a different look and beautiful scene for the elderly and can improve a wide range of sensory stimulation and aesthetic appearance. However, there may be restriction for resident to be able to explore completely the values and glamour of the garden due to safety fears. In certain instances, they are assisted to make walk round the garden and allowed to perform subtle task with close supervision. This fear brings the concern on issues of health and safety on one hand and risk attached to active performance such as falls, on the other hand and possibly balancing the two for optimal wellbeing (Parker et al., 2004; Kane, 2001). Einio (2010) identified significant principles of design that are relevant for residents of institutional care facilities as aesthetics/appearance which imply the way and manner that the building is beautifully design, painted, decorated and landscaped; orientation/way-finding which refers to the propensity to easily navigate within the facility; safety/security imply probably prevention of out-of-sight wandering and fall; accessibility and functioning refers to the availability of easy access to ambulatory

paths and devices such as grab-rails and wheel chairs; and stimulation/challenge'. Stimulating the basic sense organs such as touch, smell, sight, taste and hearing may also increase the standard of living for residents of institutional care facilities.

2.1.6.2 Legal framework and Institutional Care Facilities in Nigeria

The federal government of Nigeria domiciled the institutional care for the elderly at the Federal Ministry of Women Affairs and Social Development under the department of Social Welfare. Though, there is no national policy for ageing in Nigeria, which would have domesticated the legal framework for the establishment of old peoples' homes in the country. Whereas, the social welfare department considers the establishment of old people's home and other social gerontology care under residual care. Apart from the government agencies that run and manage social care institutions for the elderly, private individuals who intend to set up an institutional care for the elderly are usually registered as non-governmental organizations and are usually required to register with the federal ministry as such. There seem to be no legal provision for the establishment of residential institutional homes for the elderly in Nigeria. However, in the department of social welfare under the Federal Ministry of Women Affairs and Social Development, there are specific guidelines for the establishments of day care centres for the elderly in Nigeria. The guideline stated that the day care centres should have: a common hall, recreational park, medical unit, reading room/library, gymnasium, refreshment centre/café, administrative block, and perimeter fence with gatehouse.

This guideline is assumed to be the minimum standard benchmark for the establishment of a day care centre for the elderly apart from the procedural registration as a non-governmental organization that is required of a private individual. Meanwhile, since there is no stipulated legal provision in the case of residential care, it is discretionary to provide comfortable residential needs and home care facilities as an extension of the provisions stipulated for the day care centres. However, there are policy documents and guidelines available for institutional care facility provisions in different countries around the world. This guideline stipulates the terms of operation such as: The Standard Operating Procedure (SOP), framework for registration, policies and processes of administration, quality control and care processes among others. The aim of the policy document is primarily to regulate the practice of operators of these residential care facilities with a view to ensuring and preserving the quality of care for the residents of the facilities. Usually, the

framework is an enactment or act of parliament passed by the legislature of the country concerned with the responsibility of implementation, supervision and control vested on an agency or parastatal of the Government Ministry as the case may be. For instance, the Standard Care Act promulgated in the year 2000 is the general regulatory act that stipulates the requirements for establishment and operation of institutional care home in the United Kingdom. Similarly, Canada has the act of parliament tagged "the Standards and Procedure for Adult Residential Facilities" promulgated in the year 2012. Other developing countries around the world such as the Republic of Mauritius, Malta, and Austria among others have also enacted policies that guide residential care for the elderly. Some African countries such as South Africa, Kenya, and Trinidad and Tobago have also catered for legal framework on institutional care for the elderly in their countries.

It appears apparently that the first point of action by any serious government intending to provide care in principle is to make available a legal direction and framework for the kind, pattern and process of care it intends for her citizenry. Evidences available reveal that climes where institutional care for the elderly have addressed the need despair by the society resulting from the fall out of decline of the traditional family system, there is usually a policy direction and framework which must be ensured for maximum compliance. Where there is free will of operation as observed in the case of Nigeria, there may be cases of abuses and unethical practice that would make life more frustrating within the establishment that is supposed to provide succour for the residents. Legal framework for residential care facilities in other climes, for instance Canada, specifies the procedure for registration and ownership, application and approval processes, finances and costs of care, a6dmissions regulation and procedure, residents care and concerns, personnel, environment and security, social environment among others. It further specifies the staff-resident ratio, processes of care, observance of ethical principles, minimum staff qualification, and physical structure requirements among others. Other developing countries such as Trinidad and Tobago specified general regulations for establishments and operation and further criminalise violations of the regulations.

2.1.6.3 Costs of Institutional Care for the Elderly

The pattern of care an older person requires may be the major determinant of the cost of the care services rendered. Users of institutional care facilities that are not residential are likely to pay less compared to those who are resident of the care

facilities. In the same vein, the elderly with activities of daily living disabilities would expectedly incur more cost of care owing to the exigencies of their condition. Those with cognitive disabilities such as dementia may also spend more on the cost of their care except where the care is subsidised and special consideration given such as insurance. The quality of care provided in the institutional care facilities may also be an important determinant for expenditure of care. Institutional care facilities differ widely between (and within) countries in terms of how many people share a room and the amenities available, (OECD, 2005). Deductions from Khongboon and Pongpanich (2018) revealed that services rendered at institutional care facilities are numerous and they include but not limited to social, psychological and health care and the extent and quality of these services may greatly influence expenditure on care.

Cost of institutional care may also vary across country as the institutional care policies vary across nations and are greatly influenced by the socio-economic indices, culture, history and political structure (Khongboon & Pongpanich, 2018). In their recent close study on the cost of institutional care for the elderly in Thailand, Khongboon and Pongpanich revealed that in the last ten year, the cost of care at private institutional facilities was estimated for about 361 USD in government facilities and 638 USD in private facilities in Thailand. But after ten years, the figure was put at about 2500 USD at both private and government facilities. Reasons adduced for this are changes in policies affecting institutional care, modified social and health insurances among others.

Certain factors have also been reported to be determinants of costs of institutional care for the elderly. The factors were age of the elderly, (the old-old category may incur more expenses on care than the middle or early old), dependence in personal activities of daily living (elderly person who have challenges with ADL may have to pay extra carers for their optimum wellbeing), health status (those that require the services of specifics professionals in the facilities may also require to pay more) among others (Kehusmaa, Autti-Ramo, Helenius, Hinkka, Valaste, &Rissanen, 2012).

2.1.6 Predictors of Institutional Care utilisation for the Elderly

Institutional care for the elderly has majorly been reported in literature to be determined by social and economic circumstances, families and possession or lack of certain inter-related resources. The leading evidences in literature have underscored these determinants as the major background reasons for utilisation of institutional care

facilities (Townsend, 1962; Arber & Ginn, 1991; Patikanen, 1994; Freedman, 1996; & Einio, 2010). Most of these evidences are foreign and provided less coherent background for generalisation in the Nigeria context largely due to cultural diversity.

The first consideration found in literature was social and economic circumstances that are essential in the utilization of institutional care. Townsend (1962) observed the social and economic cum environmental conditions to be a possible rationale for the utilization of institutional care facilities among the elderly. He focused majorly on the homelessness, family, social isolation and financial insecurity. Townsend (1962) also identified incapacity of self-care as the most contiguous reason for the utilization of institutional care facilities. Einio (2010) reported Townsend to have categorised the activities of self-care into four basic groups which include: 1) actions that are frequently done or virtually done frequently by the individual if he or she has the ability to do them, 2) activities that are carried out by other people on behalf of the individual despite that they are able to do same, 3) abilities that are needed to be used for social communication, 4) responsibilities or activities that are essential only if the individual have some peculiar disabilities. The first category bothers on movement and the ability to do personal care, the second category, emphasises the chores to be done in the house, the third category emphasises on the sensory abilities such as seeing and hearing and so on, and the fourth category, underscores the activities required to outcome specific disabling conditions, such as eating nutritional diets and taking drugs. In the circumstance when the ability to perform adequately weakens, the likelihood for utilization of institutional facilities may increase.

Another determinant of institutional care found in literature is family. Freedman (1996) considered the effect of families on utilization of institutional care in the United States. This study stated three reason that could influence the use of institutional care by family: 1) the inability of the family members to provide personal care for the older person in need, 2) the inability of members of the immediate family to provide support towards getting the formal community-based services, and 3) the unavailability of the family ties that could have a useful impact on the welfare and health condition of the older person, and therefore indirectly affect the chances of the use of institutional care facility. The peculiar concern is why the elderly who have families that are responsible for their care would be in an institution and whether their reason for being in the institution is because of the fear that their families would not

look after them. This has been the major concern for the elderly in many societies as well particularly in a culturally cohesive society like Nigeria. However, the rise in institutional care has usually been considered as an outcome of transformation in family functions, especially the retrogressing part which has brought about a fading role of younger people in caring for the elderly.

Townsend (1962) underscored the significance of social isolation amongst the elderly who may not have family members or social network. He examined absence of social relationships, conflicts in and between the existing relationships, and the inability of family members to care for the elderly to be important factors in determining the usage of institutions. He ascribed social isolation to the lack of close family members, relative or friends, losing them due to sudden death or for some other reason, or the waning of the relationships for reasons of separation or ill-health. This analysis may provide logical guidance for the social reasons for utilization of institutional care facility. Arber and Ginn (1991) postulated the resource triangle, which explained the major reasons for the utilization of institutional care facility at old age. They posited that lack of different kind of resources may increase the tendencies for an older person to utilize an institutional care facility. They categorized these resources into three major categories which include; health resources, material resources and caring resources. This resource triangle explains dependency in old age as an unwelcoming stage of life and underscores institutional facility as a compensatory mechanism that help the elderly cope with everyday life (Einio, 2010). Health resources is referred to as the ability to provide personal self-care and care for others, material resources are defined as income, assets, housing and car ownership, and caring resources comprise of access to carers in the household and the community, taking care by personal finances. Lack of any of these types of resources is a limitation on the quality of life of the older person and may increase the risk of the elderly' utilisation of an institutional care (Arber & Ginn, 1991).

Anderson (1968) considers the use institutional care as being pre-determined by the health need of an older person. He considers the use of health services to be a function of pre-disposing, enabling and need factors. He posited that use of formal health services, which include institutional care, is a function of predispositions of families to use the services, their ability to obtain the services and their need for such services. This is because institutional care services come with complimentary health

services that readily meet the necessity to obtain health services and their need for such services. The framework focuses on the family as the unit of analysis, the argument is that family decision is a major factor in determining institutionalization of the elderly and such decision is influenced by health needs of the elderly. A further review of Anderson's framework gave rise to a reformulation of the predisposing, enabling and need factor to individual determinants, Social determinants and health service system features as important determinants of use of institutional health services (Andersen and Newman 1973). The individual determinants include variables such as age, gender, family size, marital status, among other; Social determinants include employment, social class, occupation; and health service system feature include value of health services, knowledge of diseases, and so on. A clear evaluation of the reformulated framework revealed an improvement on Anderson's framework with Arber and Ginn resource triangle. Meanwhile, predisposing, enabling and need factors are still the most commonly used concepts from Andersen's framework in empirical studies of the determinants of institutional care (Tomiak, Berthelot, Guimond, and Mustard, 2000).

a. Age and Institutional Care

The relationship between age and utilisation of institutional care has been established in literature. Several studies have shown that the very old people, the category usually referred to as the old-old (those above the age of 80) are at the higher risk of being admitted to institutional care facility. The relationship between age and institutional care has been consistent in literature. There has been report of considerable increase in the rate of utilisation of institutional care with age. Einio (2010) reported there is considerable rise in the admission of the elderly to institutional care facilities with age. The youngest group of the elderly (60-69) has the lowest probability of utilisation of institutional care. This position is clearly not different from what Townsend (1962) has observed over four decades ago. He argued that the prevalence of the elderly increases with age when other factors are controlled for particularly among the category that is referred as old-old (80 and above). The old-old are predominantly represented in institutional care facilities and constitute about eighty percent of users of institutional care. Mustard, Finlayson, Derksen, and Berthelot (1999) also indicated that the over- 80s were 20 times more likely to go into nursing home during the follow-up period than the 60–69-year olds. Furthermore,

literature has shown that there is a high measure of persistence of relationship between age and institutional care without the interference of variables such as socio-demographic and health characteristics (Einio, 2010).

It is however not surprising that the utilisations of institutional care facilities increase with age as old age has been reported to result in dependence (Help age International, 2007; Omotayo, 2009; Einio, 2010; Aikoje, 2013 & Omotayo, 2015). This is largely because the capacity to function decreases as age increases owing to the consequential body weakness due to old age. According to Einio (2010) care for the elderly in institutions is cumbersome with the category of old-old among the residents. This is because functional capacity reduces to the barest minimum and places more demands on the care givers. In privately owned homes, maintenance costs of very older citizen are higher relatively depending on the needs and upkeep of the resident.

b. Gender and Institutional Care

Differences in gender in the use of institutional care are reported in most studies (e.g. Arber & Ginn 1991; National Centre for Health Statistics 2009). It has been reported that women have possibilities of residing in institutional care facilities than men at their older ages. However, gender differences are usually based on the presumptions that women live longer compared to men because of higher male mortality rates. However, the relative effects of gender are reported differently. Einio (2010) argued on the possibility of not using institutional care was greater in men than women and it dramatically decreases with age. Einio (2010) stated further that if the demographic, economic and health characteristics of older women are relatively the same with men with of their ages, their possibility of using institutional care would have been lower and this is the case in studies of utilization of institutional care in most countries like Finland (Einio, 2010) and this is also same for studies in Manitoba, Canada (Mustard et al. 1999). Meanwhile, the case is a little lower or about the same in the United States (Gaugler, Duval, Anderson, & Kane, 2007), relative similarity in Australia but a relatively higher situation in England and Wales (Grundy & Jitlal, 2007).

c. Marital Status and Institutional Care

There have been consistent reports of life satisfaction among the elderly living with their spouses than those who are widowed, divorced or separated (e.g Einio, 2010; Aikoje, 2013, Omotayo, 2015). This implies that the old people who are married are at a lesser risk of institutional care. The indication of this could be that except for other determinants such as health and socioeconomic factors, institutional care for married the elderly may be avoidable. Townsend (1965) revealed that presence of the elderly who were not married particularly those who had never had the experience of long-time marriage were many in the institutions on a comparative measure with the entire population of the residents. Einio (2010) reported that an older person who lives with a spouse has a very probability of using institutional care. The study argued that those living alone have a high probability of utilizing institutional care when compared to the elderly living with their spouses. The study found that the elderly who have no spouses have 70% higher risk of using institutional care facilities than others. Marriage therefore is not negligible in the determinants of institutional care facilities because of its significance in cushioning the effects of loneliness and boredom that comes at old age.

d. Family Structure and Institutional Care

Role of family members in and around issues of institutional care for older person has been recurring in literature. Studies have focused more on the presence of either a spouse or children (Freedman 1996). From these results, interpretations deducted indicate that the significance of the social and emotional support rendered by a spouse and family members in mitigating the need for institutional care is substantial. The elderly themselves as important member of the family have hitherto provided long term support for relatives and children while they were active and in return are expected to be taken care of by their adult children and relative alike. The structure of family mostly determines the type of care that is expected on the elderly. Largely due to increase in life expectancy, many generations may fortunately live longer enough to see grandchildren thereby assuring a potential care and support for the elderly. Meanwhile the family structure, whether nuclear, nuclear-extended, or extended, may also play a vital role on the level and type of care for the elderly. However, extension of family structure does not independently guarantee a secured care for the older person as it may be characterized by younger generations. Largely

due to changing social norms and economic security among other factors, emerging family units within the family structure live separately without a recourse to the survival of older family members who are becoming frail and weak by the day as result of old age (Ferreira, 2005). This changing family pattern may therefore be exposing the elderly to the risk of living alone, which makes institutional care a need considering other factors alike.

e. Family size and Institutional Care

There is contentious argument on the plausible effect of size of the family on the utilization of institutional care among the elderly. From the position of Omotayo (2015), family size contributes positively to life satisfaction of the elderly; this give credence to the position of Bachand and Caron, (2001) that generally family is a source of life satisfaction. From this position, it can be argued that the size of the family will in a way determine propensity to institutionalization owing to the effect of family size on life satisfaction. How big a family is and the type of family system an older person belongs whether nuclear or extended may or otherwise determine the use of institutional care. There are presumptions that families with relatively large families where extended family system is practiced may reduce the risk of institutional care among the elderly. This could be adduced to longer chain of care givers that may be available within the family system that could render help at different times.

f. Bereavement and Institutional Care

One of the major determinants that play major roles in the usage of institutional care facilities at old age is the loss of a family member. There are studies that prove that loss of loved ones or the elderly who have lost their family or loved ones in recent time are more like susceptible to the use of the institutions than those whose spouses are still alive, and very significantly, the risk of this usage is mostly high immediately after the death of the spouse and found to reduce with time Einio (2010).

According to Nihtila and Martikainen (2008), the elderly who were bereaved during the first five years have about 71% susceptibility to use institutional care when compared to those who are still living with a spouse, without considering the effect of other factors such as income, age, education, and medical conditions. The probability of this use became very high during the first month of the death of the spouse. Einio (2010) also reported that level of education or income does not have significant

influence on the relationship that the duration of bereavement exacts on the utilization of an institution by the older person.

g. Barrenness and Institutional Care

Lack of children is a significant factor to consider as a determinant of utilization of institutional care facilities particularly in culturally cohesive country like Nigeria where emphasis is placed on the role of family especially the children in the care of the elderly. According to Togonu-Bickersteth (1997) the elderly in Nigeria place more importance on the care they receive from their children as a significant order for their life satisfaction. This implies that there may probably be depression and dissatisfaction with life for the elderly who do not have children after controlling for other socioeconomic variables. Meanwhile, studies revealed that childless women have a higher risk of utilizing the institutional care facilities than those who have at least one or two children. Similarly, Townsend (1965) has long observed that the elderly who do not have children were much in the institutions on a comparison with the general population of residents in Britain. Furthermore, Grundy and Jitlal (2007) reported that older women who have no children have about 35 percent possibility of using institutional care facilities ten years later than those with children. Freedman (1996) also posited that the elderly who have least a daughter may have little or no risk of utilising institutional care among men and women, whereas having a son only proved beneficial in the reduction of risk for women alone. This implies that daughters have more attention for both parents, while sons have strong affections majorly for their mothers.

h. Socioeconomic variables and Institutional Care

The effects of socioeconomic variables in determining the utilization of institutional care by the elderly have had varying reports in literature. Income and investment, social class, educational qualification, living arrangement, home ownership, house type, car ownership, religious affiliations are some of the variables found to have relationships with institutional care of old people. The varying degree of report of these variables on the utilization of institutional care is somewhat a concern. For instance, Mustard et al. (1999) report that there is no substantial evidence that the elderly with lower socio- economic status are more predisposes to the use of institutional care. This is consistent given the report of most studies on the determinants of utilisation of institutional care which reports majorly the net effects of

income without making recourse to the influence of other factors such as demographic, socio-economic and medical conditions.

i. Income and Institutional Care

According to Einio (2010) the effect of income may not be too significant as reported by many studies without considering the effect of other factors particularly, the medical condition. An older person with lower income could, nevertheless, be susceptible to high risk of institutional care through various health challenges arising from their income status. Meanwhile, Mustard et al. (1999) posited that the elderly who had little or no income have the higher probability of utilising institutional care. However, this report is not consistent with the position of other studies. Meanwhile, Einio (2010) reported that income does not have any effect on the utilisation of institutions at old age if there is no influence of other factors such as socio-demographic and health. Whereas, other studies affirm that the probability of using institutions at old age decreases as income increases. The implication of these results may mean that income has an effect that may be above that of health.

Many studies that have examined the relationships between socioeconomic variables and institutional care have focused more on income independently of other variables. Social status, housing condition, living arrangements, and educational qualification have been majorly ignored. These factors have been found missing in literature for quality empirical evidences.

j. Housing condition and Institutional Care

Townsend (1962) posited that poor housing conditions which deprives the elderly of comfortable living when physical disability sets in and general health status deteriorates, and homelessness were essential factors that determine utilization of institutional care facilities. Meanwhile, there a few studies in Nigeria (Wahab, 2005; Temilola; 2010) that have underscored the effects of these socioeconomic variables on old people and reported significantly their relative effects on the general well-being of the old people. Yet none of the studies focused on their determining effects on institutional care particularly the type of house the elderly live. However, foreign research evidences that exist on the effect of housing condition are particularly focused on home ownership. Ownership of a home has been reported to reduce the possibility of utilising institutional care facilities (Sloggett, and Fletcher, 1999). There are quite scanty or scarce evidences on the effect of the condition of the home, in

respect to how equipped or comfortable the elderly home may be, to determine whether availability of comfort at their homes or otherwise may determine the utilization of institutional care facilities.

k. Education and Institutional Care

The level of education of an older person may or otherwise be a factor that influences their utilization of institutional care facilities. There are presumptions particularly in Nigeria that rich and educated people are quick to request for professional care at the instant of any discomfort. Also considering the high rate of illiteracy among the elderly (Togonu-Bickersteth, 1999) there are possibilities that the vast majority of the elderly in Nigeria may be indisposed to the use of institutional care largely due to low level of information at their disposal on the comparative advantage of institutional care. Meanwhile, there are no empirical evidences on the role of education and the few reports in literature on the findings of the effects of education on institutional care are less reliable (Wolinsky, Callahan, Fitzgerald & Johnson, 1992).

l. Living arrangements and Institutional care

Living arrangements refers to whether an older person lives with a partner, with or without other relatives, living alone or with other people. The focus here is to determine the social living arrangement where the elderly inhabit has significantly determined the utilization of institutional care. Meanwhile, many studies have time and again revealed that living without a spouse gives higher chances to the usage of institutional care facilities, in Nigeria particularly, the elderly who have spouse or family members around have also been reported to live optimally (Omotayo, 2015) thereby reducing the risk of institutional care. Einio (2010) reported a study carried out in the United States among people over of 70 years of age that those the elderly who live alone have 80 percent susceptibility of using institutional care facilities than those who live with their spouse.

m. Health related factors and Institutional care

Health trends among elderly people are complex. Most studies have adduced health related factors for utilization of institutional to functional impairment and cognitive impairment. These two health conditions have been found to have increased

risk of utilization of institutional care for the elderly. Functional impairments in this context refer to restrictions in daily activities or to instrumental activities. These may imply aspects of poor or bad health, which may include physical disability and cognitive impairment, even when they simply perform different functions, they still control activities together. Daily activities may include primary responsibilities and function that every human must carry out independently of anyone such as bathing, eating, dressing, going to the toilet, moving around. Whereas, instrumental activities refer to more complex functions which may or otherwise require the assistance of others, yet individuals can do them independently such as doing shopping, using banks, cooking without assistance, among others (Einio, 2010). There are reports in literature that suggest that the elderly have challenges with activities of daily living, the higher their probability to use institutional care facilities (e.g. Fendrick, Foster, Herzog, Kabeto, Kent, Straus, & Langa, 2004). Meanwhile, Einio (2010) reported that similar to the inability to do daily activity, instrumental activity too may put the older person to a high risk of utilising institutional care when they are constantly dependant on other people. He reported further that the elderly who have more incapacity are two times susceptible to utilize institutional care facilities than those with no dependencies.

Also, cognitive impairments have been found to determine utilization of institutional care (Coward et al. 1996). Out of many cognitive disabilities among the elderly, dementia has been reported to predict a higher risk of untiring institutional care (Einio, 2010). It further stated that dementia has more excruciating effect on the use of institutional care than the limitations in daily activity and instrumental activities. There is overwhelming evidence that daily activity and instrumental activity dependencies and dementia are major health determinants of utilization of institutional care facilities. However, the effect of other medical conditions is relatively scanty in literature.

Meanwhile, there have been inconsistent reports in literature on the impacts of other types of diseases as determinants of the elderly' utilisation of institutional care facilities. Some studies have underscored the effects of arthritis and hypertension, while others have emphasized Parkinson disease, diabetes, and stroke as plausible determinants. These inconsistencies in report have given credence to further research.

Deductions from Sibuh (2015) indicated that there is restricted ability to treat efficiently one of the most disabling common disorders, cognitive disability, and the accumulating load of disease due to the ageing scourge. For the elderly to remain healthy and independent there must be a substantive provision of a supportive environment which expectedly should include a befitting living condition, access to economic resources and proper health care (Jang & Kim, 2005). Sibuh (2015) argued that in developed countries where there is huge provision for acute care and institutional care services for the elderly, there is evidence of unprecedented increase in the use of medical care services by the elderly as their age increases and per capital expenditure on health care is relatively high among the elderly. Consequently, the unprecedented increase of older person's population is placing rising pressure on general health care expenditure in the developed nations, although other factors such as income increase and technological advances in medicine generally has a huge significant role to play. Health arrangement for the elderly that strengthens health at old age must go beyond care to respond to the presence of illness. Given the important institutional long-term implications, this remains relevant even in the current period of financial and economic turbulence.

Conversely, as much as population ageing may pose some extra costs, this excess burden could be remediated by the use of suitable and carefully administered health and social policies that reduces the rate of health challenges that are related to ageing and subsequently the amount of health care services required. With an increasing number of chronic conditions, older patients are by the demand of necessity required to see a number of different professionals who would provide both social and health care services.

2.1.7 Institutional care and the Elderly with Long Term Condition

The elderly are the most susceptible group or population at risk for long term condition due to their general body weakness which may therefore necessitate a long-term provision of care. Fisher and Scragg (2012) defined long term condition as a state of health status that cannot be cured but only managed through various medical interventions. This implies that a long-term condition has no cure and it may be permanent till the end of the individual life. Long term condition was particularly categorized based on the perceived causative factors. These factors as identified by Fisher and Scragg (2012) are; inherited congenital, acquired and degenerative factors.

This classification of plausible causes of long-term conditions in the elderly is based on the presumptions of physio-structural analysis of the body system and their interaction with development of illnesses in the human body. By inherited factors, these are the diseases and illnesses that are imbue in the genetic composition of human body which are acquired from the human body; the congenital factors are self-developed, the diseases and illnesses that sprout out probably during the multiplications of the cells in the body as a result of organ malfunction; the acquired factors may include infections gotten as a result of life styles; and degenerative factors are the anomaly that begins to set in as a result of body weakness to battle with life recourse. The degenerative factors are particularly more relevant to the elderly long term condition because diseases and illnesses that set in at old age are mostly due to general wear and tear of the body tissue, except otherwise, if the older person has lived with the condition since younger age. However, some long-term condition of the elderly may set in only at their old age which may be traced to their parental source. This could only mean that such disease has been in the body system but was kept docile by the body mechanism, which was still very active until old age sets in, and deterioration begins to prevail.

From the foregoing, the implication for the elderly is that they are more vulnerable to long term condition as a result of the elderly' easy susceptibility to diseases owing to tear and wear of the elderly' cells and tissues hence limited ability to combat diseases. Therefore, most people with long term conditions are the elderly. For instance, in the United Kingdom, it was reported that long term condition affects about 15.4 million people and three out of five people which accounts for 60% are aged 60 and above (Department of Health, 2010). Fisher and Scragg (2012) also reported that 80% of primary care consultations and two-thirds of emergency hospital admissions in the United Kingdom were related to long term conditions and levels of chronic illnesses are predicted to increase as the population ages. This brings to the fore the need for an arranged mechanism to cater for the long term conditions of the elderly which may include paying attention to health and social services which may improve the quality of life and wellness of the elderly.

With these long term conditions, the elderly may have difficulty in meeting up with demands of many aspects of their personal lives, carrying out their daily routine, and therefore placing a lot of dependence on people around them and needing the

support of professionals to ease their medical and psychosocial burden with strong regard for their decisions on independence and quality of life. Meanwhile, the pattern of support and assistance required by the elderly with long term condition may vary largely depending on the type, nature, status of their condition. In a report by the United Kingdom's Department of Health (2010), long term condition was categorized into the following; first, those that have the most complex needs; secondly those with medium needs and those with conditions that are relatively easy to control. This categorization defines that kind of support that an older person with long term condition may require. The first identifies the need for those with terminal diseases and illnesses. These include the elderly that have been presumed to have capacity to live not beyond specified time owing to the deteriorating health conditions. These individuals require a very large attention and continuous bio-psychosocial interventions for optimal care and survival. These are the elderly with illnesses such as cancer which may require permanent residential care among many others. The second category, are those with acute illnesses and diseases but possessed enduring capacity to survive if they receive proper care and attention. They may not require a resident care facility but would still depend largely on the support of professional service providers. The elderly with diseases such as diabetes fall within this category. The third group is those with long term conditions that have very mild effect on their bio-psychosocial statuses. These conditions though unpalatable, does not steal totally from them their active independence and sustenance.

The Department of Health, UK, (2010) categorized persons with long term condition into three, those that have the most complex need, those with medium needs and those with relatively easy condition to control. The study further categorized the management of long-term conditions into four broad interventions. These interventions are; case management with personal support from skilled professionals; personalized care planning with a person-centred approach; supporting people for self-care through provision of information and skills to enable individuals manage their health and assistive technology using emerging technology to support people for independence and self-care. The submission above relates to the needs of individuals with long term conditions. The individual with relatively easy condition to control may require only one of the interventions owing to the nature of their condition. For instance, an elderly person who suffers from an injury as a result of fall and becomes

partially unable to work may require only assistive technology to support his/her movement. Also, individuals with most complex needs may require all the interventions in the model. However, the model has failed to put into consideration the relative significance of family support and social networks. This may be as a result of weaning off and disintegration of the family structure in the United Kingdom.

Furtherance to the above, the National Service Framework for Older people (DH, 2010) identifies eight standards to be used in the care of the elderly. The standard is designed to provide care based on clinical needs and not age. This implies that the age of the elderly does not particularly matter in the management care but the needs required by the condition of the person. The standard sets that services treat the elderly as individuals, promoting their quality of life, independence, dignity, and their right to make choices about their care.

2.1.7.1 The Elderly and Prevalent Long Term Conditions

The increasing number of the elderly and their susceptibility to illnesses and diseases owing to general body weakness are the major causes of larger number of people with long term conditions as the elderly. From the position of literature (DH, 2010; Einio, 2010; Fisher & Scragg; 2012) the population group commonly with long term conditions is the elderly. While the long-term conditions cover wide spread of spectrum, Fisher and Scragg (2012) identified the peculiar conditions that are common among the elderly. Although individuals may have more than one condition of health which has caused them functional incapacity, yet medications for one condition may aggravate the other. This implies that the commonly identified conditions with older person are not exclusive as posited by Fisher and Scragg. Some of the classifications of the prevalent conditions with the elderly include; conditions affecting the respiratory system which includes chronic obstructive pulmonary disease, such as chronic bronchitis and emphysema; conditions affecting the cardiovascular system such as heart diseases/failure and stroke; conditions affecting the nervous system such as Parkinson's diseases and multiple sclerosis; conditions affecting the metabolic system such as Diabetes mellitus; and Dementia. Other conditions may arise from fall or accident which may put the elderly on a permanent

or long term conditions. This classification is missing from the Fisher and Scragg's classification.

The management of the elderly becomes a source of concern especially for the care providers. The family system according to Omotayo (2015) remains a major source of succour to the elderly in Africa. Studies around the world (Bowling, 2005; Jackson, 2009; Gaylard, 2012; Fisher &Scragg, 2012) have also emphasized the significance of family system in the management of the elderly. Though older people with long term condition may require more professional help, whereas, a large number of them rely substantially on informal care which according to Berry (2011) constitutes a third frontier in the care delivery. Other studies (Harris et. al, 2003, Fisher & Scragg, 2012) have substantiated the significant contributions of informal care for the elderly with long term condition. They posited that most of the cares received by the elderly with long term condition are informal. Yet these arrangements have not substantially taken care of their need as informal care givers do have limitations of care provisions such as dramatic effect of care provision on them, negative effect of service provisions, and distress about behavioural and social problems among others.

The growing technological advancement has been of great advantage for the elderly living with long term condition. Assistive technology includes a number of equipment and processes with the objective of providing independent living for the elderly (Fisher & Scragg, 2012). These assistive technology tools are designed to improve the quality of life of the users, sometimes through remote monitoring. The devices include heightened toilet seats, automotive wheelchair, furniture raisers, tele-care, among others. This assistive technology has proven to support the elderly with long term conditions through provision of guidance in spotting areas of their daily routine that could be aided by their simple equipment and health improved tele-care facilities.

2.1.8 The Elderly and Contemporary Issues

The elderly are integral part of the population in the society and not just passive member of the society. They are relevant population group whose wellbeing should be addressed for optimal living. The contemporary ageing population has given rise to new occurrences that are consequences of increasing number of the

elderly. There are incessant reports of activities around the world that give concern on the prevalence of the increasing number of the elderly. Omotayo (2016) posited that the elderly are getting more involved in societal activities that are once presumed to be exclusive in the domain of young people which include crime, marriage and sports. For instance, in crime, Dumo (2015) reported that an older person mummifies the dead mother so as to collect her 300-dollar pension. This a criminal act that involves older person against another older person. It goes to show the importance of pension to human survival. In addition, the elderly are being used as couriers of hard drugs. According to Ajulu (2015), a 92- year old Nigerian is in prison for drug offence. While another 92 -years old was arrested while trying to traffic drug to Sau Paulo in Brazil. It was reported that her children put the drug on her. This is a clear case of abuse on an elderly person probably owing to ignorance on the part of the elderly which attests therefore to the vulnerability of the elderly.

The elderly are also reported to have been involved in domestic violence; according to Akenzua (2015) an older person in Delta State Nigeria was arrested for slapping his daughter in-law over meal and accusation of theft. From literature, it has also been gathered that the elderly are getting involved in dangerous criminal activities such as armed robbery. From the submission of Adeyi (2015), an 80- year old man was arrested in Lagos state for arms possession. Similarly, another 80 years old man with 71 other individuals were arrested for gun running in Edo state (Ojauzo 2015). While in a related case Oloker (2015) reported discovery of fifteen thousand ghost pensioners by the Federal Government of Nigeria. Conversely, the elderly have also been reported to be victims in which circumstance they have been helpless. For instance, in Benue state, an 80 years old man was butchered as she was accused of witchcraft and dumped in a gutter in Otukpo Local government of Benue State (Ganagana 2016). Similarly, according to Onuoha (2016) in Abia state Umuahia to be precise, a 72 years old man was attacked and almost killed when he was robbed on his farm.

Meanwhile, it has been observed that the elderly are getting involved in issues uncommon to the population group; these are activities that are generally in the purview of young generation because they are energy demanding. For example, from the submission of Adelola (2015) an older person, Mieko Nagaoka at 100 years old completed 1,500 meters of swimming competition in Japan. Also, Adelola (2015)

asserts that Harry Nelson from United States of America is a 90- year old man who has appeared most in the Olympics Games for 18 times, the last was in 2012. While Diana Gihum at 100 years old is the oldest Olympics torch bearer. This depicts the fact that the elderly in contemporary time are active participants in societal endeavours. In relation to love and romance, the elderly are active actors on issues that relate to young adults such as divorce. It was reported by Vanguard New study (2015), that an 84- year old Italian divorced her 88 years old husband owing to erectile dysfunction and reduction in sexual intercourse to three times in a month. Such occurrences point to the fact that age is not an inhibition to sexual enjoyment. Furthermore, the issue of divorce as reported above has become intergenerational as it cuts across all generations. In addition, it has also been reported that regular sex reduces dementia at old age and sex stimulate anti-ageing hormones (Ajal 2015)

Arising from the above, the issue of ageing and harsh treatment of the elderly has opened new frontiers for policy and legislation by some nations in the world. Consequently, from report in China, it is illegal not to visit and meet financial needs of aged parent (Adewale 2015). On the other hand, new technologies are being designed to accommodate the growing number of the elderly. Akinyele (2015), reported that a robot has been designed which can assist care giver to the elderly to move them with easy and enables them to move their limbs according to intension; it is a wearable robot that also provides lower back support that is very essential for older population. From this submission, it can be deduced that the elderly are population group that cannot be ignored. This is because the elderly are active participants in social and economic issues such as marriage, family, divorce, sports, crime and finally influencing policy formulation and discovery in science and technology which will eventually provoke and delineate social and economic perspectives such as the budget in relations to the elderly and open new frontiers for academic discourse. It is crystal clear that if the issue of old age is harnessed, the elderly are asset and not a liability to any society. Meanwhile a number issue that have put the elderly at risk are hereby discussed thus.

a. **The Elderly and Abuse**

Generally, elderly abuse is usually referred to as ageism. This is the process of systematic stereotype and discrimination against people because they are old. Hooyman and Kiyak (1996), has linked ageism to attitudinal problem among the

elderly. Owing to the fact that this study concerns the issue of the elderly in relation to care, therefore, it is preponderant to give scholars submission on the issues of ageism. It can be deduced that issue of ageism is similar to denial of right. This segment of the research presents this from different perspectives. According to Butler and Lewis (1973), ageism is the process of systematic stereotyping and discrimination against people because they are old. In furtherance of this argument, Johnson et. al. (1997), argued that in many cultures, there are stereotyped and prejudice against the elderly. Such include the belief that the elderly are less intelligent, senile, rigid and parochial. Though these traits are often found among the elderly than any other population group, but it will be wrong to perceive all the elderly as such. Consequently, the elderly are often viewed from this preconceived notion and it has affected the attention and attitude of the society towards them. According to Foos and Clark (2003), ageing is as a result of wear and tear of cell occasioned by lifetime of random illness, injuries and damage to the body. This is responsible for older person's mental and physical decline.

From the submission above, ageing is a natural process with its unique consequences such as mental and physical frailty that demand unique methodology in relating with the elderly. However, the society has not properly recognized this fact by addressing the issue of ageing and increasing number of the elderly with tact and urgency it demands (Help Age International 2007). The society has continued to give limited attention to issues concerning the elderly, which from the position of various scholars has mutated into circumstantial denial of the older person's right.

b. The Elderly and Stereotype

Old age is usually perceived as a state of general weakness and inactive. The society's perspective of the elderly is demeaning as though they are continuous dependant on the society and could hardly do anything for self-sustaining. Older people are usually assumed to have needs, desires and characteristics that are similar (Tanner and Harris 2008). Smethurst (2012) posited that older people are typically perceived as 'wealth consumers, rather than wealth creators, and as a threat to national economic growth.' Similarly, older people are presented as a real, or potential, economic and emotional burden on the younger population (Stevenson 2008). Within this context, the needs of older people are frequently considered within a narrow paradigm of care and dependency, placing them in a subordinate position

which objectifies and devalues them (Calnan, Badcott, & Woolhead, 2006; Llewellyn, Agu, & Mercer, 2008). Stereotypes form the basic set of beliefs that informed our thinking and behaviour of the elderly. Our society often think old people are at the mercy of the younger generation for optimal survival and they are considered less productive. Hall and Scragg (2012) posited that the stereotypical view of ageing and the elderly is essentially negative both as individual and as a group. The elderly are stereotyped as being dependent and parasitic, weak and frail, unhappy and tired with life, senile, disengaging from relationships and consequently waiting for death.

Stereotypes meddle with the way we treat and react to the elderly in the society. Negative stereotypes push us to label and consider the older population as being particularly unproductive and weak. It informed the reasons why the focus of the society on productivity and development is shifted on the younger generation. Stereotypes also have a great influence on the way the elderly perceive themselves and therefore interfere in their wellbeing and life satisfaction (Omotayo, 2015). This implies that the labelling and tagging of the elderly especially to something negative disturbs their psyche and overtime they tend to accept the situation. However, stereotypes have also assigned particular roles to the older person especially in the African society where the elderly are revered as a repository of wisdom (Omotayo, 2012).

The elderly conceive negative stereotypes of ageing which shape their expectation and behaviours leading to lower expectation of material wellbeing and quality of life (Kite & Wagner, 2004; Dominy & Kempson, 2006). Negative stereotypes have been reported to impede the general health, wellbeing and life satisfaction of the elderly. The elderly with perceptions of negative stereotypes are characterized with depression and low self-esteem. They display negative response to stress, have low self-efficacy, impaired cognitive functions and generally have negative views about others (Hall & Scragg, 2012; Levy, Ashman, & Dror, 2000). This implies that stereotypes greatly affect the thinking, performance, attitude, behaviour and general health of the elderly. The same way negative stereotypes could be detrimental to the wellbeing of the elderly; positive stereotypes have its beneficial effect. Positive stereotypes could increase self-esteem and efficacy, performance, and life expectancy (Levy et al, 2000).

c. The Elderly and Discrimination

Older people with problems such as mental challenge face the combination of age discrimination coupled with the stigma of mental illness (Gaylard, 2012). Age discrimination itself is enough to battle with following the general notion of weakness as product of ageing and disengagement which is consequential. Meanwhile, discrimination of whatever form can lower self-esteem, sometimes leading to feelings of worthlessness and despair. The result may be lowered expectations of rights and capabilities that prevent older people from contributing to society and enjoying life to the full. Our individual identities are not solely determined by our age but by many other factors, for example, our beliefs, race, gender, gender identity, disability, religion and sexual orientation. Although people may face discrimination as a result of any of these aspects of our identity or any combination of them, there is still a service provision tendency to 'classify', segregate and congregate older people together simply according to age. Yet all these factors can be as relevant to older people as younger people (Gaylard, 2012). Older people are often perceived as being 'less worthy' than others. One result of such devaluation is social rejection, separation and exclusion. This can lead to older people being denied or having restricted access to things that we, as citizens, value and take for granted. In turn this becomes a vicious cycle; less opportunity leads to less participation, which in turn leads to an older person withdrawing and becoming isolated. The loss of valued relationships, respect, autonomy and participation are exactly the kinds of experiences that bring about depression, despair and isolation – factors which often consistently correlate with suicide in older people.

Another way society often responds to such claims is to express a view that the elderly choose to do these things as it's about them disengaging from the world and as such a part of growing old. Some people do prefer the company of other older people and do want space to reflect and look back on their lives; but not at the expense of all the other kinds of possible experiences they could have. Growing older is part of life but older people like everyone else have the right to engage and participate in all aspects of community life (Beeston 2006). This may appear a somewhat bleak view but it is vitally important to recognize the possibility that discrimination, devaluation or rejection may lead to an older person believing that they are a 'burden' or a source of anguish to others.

d. The Elderly and Depression

Depression is not normal in later life but is common in later life; it is a significant factor causing severe health problems and it remains a major public health concern (Godfrey 2009). Depression affects how people feel about themselves and the world around them, engendering a sense of worthlessness, the surrounding world as meaningless and the future as hopeless. The impact of depression can have global consequences on a person's daily life including sleep, appetite, energy levels, interest in social activities and participation. Later life depression prevents a person from enjoying things in which they previously found pleasure and can impact upon concentration. It has a negative effect on functional abilities, and is a major contributory factor in morbidity and mortality (Gaylard, 2012).

Depression repeatedly features in research into suicide among older people. Hirsch, Duberstein, and Unutzer (2009) sought specifically to distinguish depression from physical health factors in suicide. Their study of almost 2000 older primary care patients found that 'happiness'– positive mental health – broke the link between physical health problems and suicidal feelings; with an association between physical health problems and suicidal thoughts, but those with positive mental health – despite physical illness – were less likely to feel suicidal (Jackson 2009). One in four people aged over 66 suffer from depression, 22 per cent of older men and 28 per cent of older women. Of these, half are considered to meet the threshold for a severe depression diagnosis (Age Concern 2008). Two in five older people who live in care homes have depression, yet an Age Concern (2008) report comments they are all too often undiagnosed, untreated and at risk of physical health problems, premature death and suicide. Risk factors for depression remain similar to those for suicide. Primary risk factors are money worries, stressful life events, bereavement, social isolation and loneliness.

Older people often have fewer resources to do anything about these factors, inevitably remaining exposed to bereavement; physical frailty may limit their ability to stay socially active or meaningfully engaged with their communities. Beeston (2006) argues that older people also face greater obstacles in attempting to achieve positive mental health highlighting age discrimination and social exclusion. Dennis, Baillon, Brugha, Stewart, Meltzer, and Lindesay (2007) confirmed the association between depression and lack of social support networks, being widowed, poor self-rated general health and physical disabilities. Goldens, Conroy, Bruce, Denihan,

Greene, Kirby, and Lawlor's (2009) study of nearly 1300 older people from Dublin discovered that 35 per cent were lonely and 34 per cent had very little in the way of social support networks. A third of those with good social networks still described themselves as lonely. Poor well-being, depression and hopelessness were associated with loneliness and poor social networks; loneliness was strongly associated with depression and being widowed.

e. The Elderly and Mental Health

Gaylard (2012) argued that there is a widely held view that older age is inevitably a period of physical and mental decline. However, only a minority of older people experience severe and enduring mental illness and much can be done to ameliorate both the risks and symptoms of the key mental disorders associated with later life (ONS 2004). Significantly, mental health is routinely identified by older people themselves as pivotal to ageing well (Bowling 2005). Research consistently identifies that having a purposeful role, social status, good social relationships with family, friends and neighbours, an adequate income, remaining physically fit and living in a supportive neighbourhood, promote mental health (Age Concern 2003). Issues that older people identified as undermining mental health were their exit from the labour market (forced or planned retirement), deteriorating physical health, loss of independence, loneliness, fear of death, living in poor housing or neighbourhood and a decreased income (Victor 2005). The negative impact of losses tends to accumulate in later life, with physical illness being a key risk factor for developing mental health problems, particularly depression (Godfrey and Denby 2004). Loneliness is also a major factor leading to depression and an important cause of suicide and suicide attempts. How well older people adjust to late life challenges remains a key factor in determining their mental health. Those older people who are able to adapt well tend to fare better (Robinson, Clare, and Evans, 2005).

Layard (2006) posited that in knowledge economy, lifelong learning and sound mental health are increasingly important to economic attainment and social cohesion. Layard (2006) identified eight key factors for a sound mental health: emotional and spiritual resilience; an underlying belief in self-worth and the worth of others; an ability to interpret the world around an individual and positive influences; realizing self-abilities; being able and willing to contribute to society as a citizen;

creating positive relationships with the world around us; sustaining mutually satisfying relationships and taking control of our lives as much as possible.

f. The Elderly and Nutrition

Nutrition, from the submission of scholars such as Udoh (2000), is the process by which food is taken into the body to provide nourishment to the cells. It involves ingestion, digestion, and absorption of nutrient into blood stream and utilization for the benefit of the body. It is the nutrients that empower the body to carry out its function appropriately. Such function includes growth and repair of body tissues owing to tear and wear and necessary metabolism within the body. In relation to the elderly, adequate nutrition is most important owing to age that necessitates close monitoring of food intake owing to weakness of body organs that naturally accompany old age. Hence, the issue of diet that relate to appropriate choice of food becomes important at old age. This is because having the right diet is rudimentary to ingestion of essential minerals for body use, especially when the body is naturally weak.

From the submission of Omotayo (2010), food is an essential constituent of human daily activity owing to the fact that it is a source of pleasure. In addition, it enhances good health; the fulcrum for long productive life, devoid of disease and illness. Good nutrition have been identified as a major means of addressing health challenges such as type 2 diabetes, heart disease and hypertension. Owing to the importance of food, additives such as salt and other ingredients are added to food to make it tasty. Besides, food is the foundation of human wellness, as it provides human being with all requirements for daily activity (Omotayo 2010).

From the position of Udoh (2000) there is no necessary increase in nutrient intake for the elderly. A varied diet is necessary, but the elderly should increase intake of minerals such as calcium, iron and vitamins such as A, C, B –complex owing to loss of appetite for food that contains these minerals. However, there is the need for fewer intakes of carbohydrate and protein foods owing to fewer requirements for energy. Mineral level and vitamins requirement of an individual remains the same even at old age; hence consumption of mineral and vitamins by the elderly should not reduce. In support of this claim, National Institute of Health (2000) stress the need for the elderly to take food rich in calcium than taking calcium supplement owing to the fact that food that contain calcium is easily absorbed than calcium from supplement.

Therefore, food such as skimmed dairy product like milk is essential for the elderly as it contains calcium that is necessary for the prevention of osteoporosis. Thus, the consumption of stable food like rice becomes less frequent by the elderly. However, from the argument of Omotayo (2010), the use of seasoning to enhance food taste helped the elderly in addressing the challenge of palatability. Apart from cooked food, other edible plants of benefit at old age are vegetables, fruit and bitter kola (orogbo). This is because these contain chemical compound that help in the breakdown of glycogen in liver and other medicinal uses which assist in longevity. Besides it provides energy and enhances the immune system; an essential input for wellness at old age.

From the submission of Nwakolo (2011), the elderly did attribute their longevity to God's gift. But the major reason for longevity has been attributed to diet that is devoid of adulteration, minimization of artificial seasoning and maximization of natural seasoning such as locust beans. Thus, the use of natural seasoning should be encouraged at old age.

g. United Nations and The Elderly

The increasing number of the elderly has been an issue of concern in the developed nations for decades. This scenario necessitated the need for international convivial such as Vienna 1982 in which the United Nation put the issues of increasing number of the elderly on the fore burner. Sequel to this and owing to further development and social consequence of increasing number of the elderly, It becomes imperative to ensure necessary step in addressing the increase in the population of individual above the age of sixty. Owing to this scenario the United Nation did had the Madrid International Plan of Action on Ageing in 2002 which include five major position which include independence; participation; care; self-fulfilment; and Dignity. Independence depicts that the elderly should have access to adequate food, water, shelter, clothing and health care; opportunity to work or to have access to other income-generating opportunities; participate in determining when and at what pace withdrawal from the labour force takes place; access to appropriate educational and training programmes; live in environments that are safe and adaptable to personal preferences and changing capacities; and able to reside at home for as long as possible. Participation, which is the second factor identified by the United Nations means that the elderly should remain integrated in society, participate actively in the

formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations; seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.

Care to United Nations implies that the elderly should benefit from family and community care and protection in accordance with each society's system of cultural values; have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well- being and to prevent or delay the onset of illness; access to social and legal services to enhance their autonomy, protection and care; utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment; and enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to decide about their choice of care and the worth of their lives.

Self-fulfilment of the elderly involves that the elderly should be able to pursue opportunities for the full development of their potential; and have access to the educational, cultural, spiritual and recreational resources of society. The last factor posited by the United Nations on the concern for the elderly is dignity. This implies that the elderly should be able to live in dignity and security and be free of exploitation and physical or mental abuse; treated fairly regardless of status, and be appreciated without recourse to their economic contribution. From the United Nation Position in 2002, it became glaring that the issues of ageing are water shed as it permeates every strata of the society from finance, education to housing.

In Africa the consequence of increasing number of the elderly is having effect. One of such is the increase in the number of pensioners that demand the need for contributory pension in 2004 and the review of the sachem in 2014. Other consequences of ageing transcend the social issues but include commercial issues such as advertisement. Owing to all these positions the issues of ageing population has become an emergency that must be addressed in all forms.

Omotayo (2014), argues that the issue of ageing is affecting a number of social and economic institutions and one of such is the concept of old people home. Though naturally in African as old people are expected to be cared for within the extended

family system in Nigeria. But owing to a number of factors such as dual-earners family, fewer number of children, urbanization and socialization, the issues of older people home is becoming a norm as the number has increased over the time from preliminary observation.

h. The Elderly and Sustainable Development Goals

The concern of this study here is to show the relevance of sustainable development goals to the issues of ageing in general and how specific goals such as poverty and fight against hunger cut across all population group in which the elderly' are not exception and institutionalization is necessary. Also, goals such as good health; well-being; quality education; gender equality; clean water and sanitation; and affordable energy directly relate to wellbeing in old peoples' homes is the direct focus of this study.

Sustainable Development Goals (SDGs) is a continuation of the Millennium Development Goals that are refocused universally among the member States of the United Nations for the achievements of measurable goals which are expected to guide the framework of policies and agenda of the States for the next fifteen years. According to United Nation (2016), the Sustainable Development Goals are United Nation's initiative that is designed to transform the world by 2030. The Sustainable Development Goal has seventeen Goals with 169 targets.

The United Nations in September 2015 in her seventh General Assembly adopted a number of regulations and set goals with the aim of addressing a number of world challenges such as poverty by 2030. There are seventeen goals which are to replace the eight Millennium Development Goals (MDGs). The 17 goals are: End to poverty; Zero tolerance to hunger; Good health and well being; Quality education; Gender equality; Clean water and sanitation; Affordable and clean energy; Decent work and economic growth; Industry innovation and infrastructure; Reduce inequalities among countries; Build sustainable cities and communities; responsible consumption and production; Climate action; Conserve sustainable use of ocean; Protect sustainable use of terrestrial ecosystem; Peace, justice and strong institutions and; Global partnership for the goals. Therefore, it is posited that for the next fifteen years or more years the seventeen goals are to drive and guide global effort on issues relating to poverty, gender, housing and climate. These are contained in 54 United Nations Resolution A/RES/70/1 of 25 September 2015.

The concern of this study is to enumerate the links between the SDGs and the concept of institutional care for old people. Meanwhile, there are One hundred and forty seven countries heads of states government and one hundred and ninety one nationals that adopted it. While the Millennium Development Goals (MDG) that metamorphoses into Sustainable Development Goals SDGs has 8 goals, 18 targets and 48 indicators, the Sustainable Development Goals has seventeen Global Goals with 169 targets involving 193 countries and civil group. The number of goals identified with the elderly is further x-rayed. In the first instance the issues of poverty cut across all population group in which does not exempt the elderly, thus poverty concern among the elderly may consequently resolve to institutionalization. This is because extended family system from deduction into Aikoje (2013), has weaned. From this position however, it can be argued that institutionalization of the elderly may be an alternate identifiable means of caring for the elderly owing to the indefatigable nature of poverty that demands multiple actions as solution.

The second goal of SDG is good health and well-being and this is important to the elderly. This is due to the susceptibility of the elderly to vulnerable situations owing to socioeconomic inadequacies and denial of right to the elderly. Precarious health conditions that results from the inevitable tear and wear of the body has also raised the concern for the elderly on their health and wellbeing. Meanwhile Omotayo (2015) argued that there are less research and limited information and knowledge about issues such as health of the elderly. With growing interest on the health and wellbeing of the entire population with keen attention on the vulnerable population groups which includes the elderly, there is hope for a paradigm shift on the health and wellbeing of the elderly.

The fourth goal which is quality education is essential to needs of the elderly. Adesomoju (2016) reported that an eighty years old man became a graduate from the Nigerian Law School. It shows that the elderly are not excluded in knowledge acquisition even at tertiary level. This implies that the concept of education in relation to the elderly is not limited and there is need to ensure that such needs are met even at institution that cater for the need of the elderly such as old people homes. The fifth goal of the SDG has to do with gender equality and the concept of gender equality is traditional. For the advancement of such issues, the elderly are germane owing to the

indelible roles they play towards socialization. From the position of Omotayo (2012) the elderly are identified as custodian of culture and tradition in terms of knowledge and practice. Hence, there is involvement of the elderly in achieving this is essential. The sixth goal that concerns clean water and sanitation and the seventh goal affordable and clean energy is important to the wellness of the elderly in institutional care facilities such as old peoples' home as such utilities have been found to contribute to the elderly life satisfaction (Omotayo, 2015).

The eight goal which talks about decent work and economic growth and the ninth goal which emphasizes on industry, innovation and infrastructure have a link with the issues of plasticity and second job after retirement which has become rampant among the elderly. From report Astrid Thoeng at the age of 100 in Parsi, New Jersey still works in United State (Osinusi, 2009). Muyana (2009) reported that, about 2,500 retired Midwives were employed by Federal Government of Nigeria to assist Primary Health Care. Meanwhile the concept of pension for budget funding has made the elderly (retirees) a viable economic population group. Even the evolution of old people home is bound to change family structure and create jobs as argued by Omotayo (2014).

The issues of SDG eleventh goal which bothers on sustainable cities and communities will promote wellness for all population group and the elderly are not exception. The twelfth goal which addresses responsible consumption and production has to do with health promotion that has been argued as essential ingredient at old age (Bulugbe, 2013).

The thirteenth SDG goal on climate action; fourteenth goal which protects life below water and fifteenth, life on land life concerns the elderly in relation to gathering support and conviction of other population group as the elderly experience will be an added value to this campaign. The concept of peace, justice and strong institutions and partnership for the goals generally brings to the fore the importance of all population group in achieving the Sustainable Development Goals (SDG).

i. The Elderly and African Union

The African Union in 2002 during the 38 session of Head of States and Government in Durban South Africa encourage members' state to design, implement, monitor and evaluate appropriate policies and programmes to meet the individual and

collective needs of the elderly in Africa. The framework has 13 key areas of concern to the elderly in Africa and a comprehensive guide for member states on how to develop policies and programmes to meet needs of the elderly. It is interesting and encouraging that the African Union has prioritized the issues of ageing in Africa in which nutrition is an integral concept of the policy. The concern is to ensure that the elderly have access to adequate food, nutrition, production and marketing. The initial target is to develop food and nutrition policies that address the specific needs of the elderly as well as those aimed at improving the nutritional status of all age groups thereby ensuring right nutrition as they enter old age.

2.2 Empirical Studies

Many studies have examined the determinants of institutional care facilities among the elderly around the world. A host of these studies have use national based population representing the entire the elderly, age 65 and above while others have used a regional based population (Tomiak et al. 2000; Grundy & Jitlal, 2007; etc). Common to these studies are the identified determinants of institutionalization for the elderly conceptualized as either predictors, pre-disposing factors or risk factors of pre-admission in institutional care facilities, which were mostly based on either longitudinal, cross-sectional or prospective studies. Most of these studies also adopted the Anderson's framework on use of health care which conceptualized institutional use as pre-disposing, enabling and need factors as discussed earlier.

Largely due to the methodical difference and varieties in the population use of most of the studies, there appear to be varying degree of reports on the determinants of institutional care facilities for the elderly. Notwithstanding this variation, all these studies have provided empirical positions and evidences on the factors identified either conforming with Anderson's framework or deviating therefore. Most studies that used the Anderson's framework (e.g. Grundy, 1992; Grundy and Jitlal, 2007; Wu et. al. 2014) underscored the predisposing factor as the; demographic factors such as age and gender, social characteristics such as level of education, and health beliefs. The enabling factor were identified as personal/family factors and resources such as household income, marital status, number of family and place of residence and the need factor as the immediate need for the institutionalisation which is based on health status of the older person which include impairment of activities of daily living (ADL) or Instrumental activities of daily living (IADL).

Cursory review of other studies points to the summarily identified determinants with or without categorisation to include Age; Gender; Housing (own or not own a house); Ethnicity (or region of residence); Self-rated health status (low, fair or poor); Functional impairment; Cognitive impairment; Dementia; Prior institutionalization; Number of prescriptions; Employment status; Social network (high, moderate or low contacts); Activity level, (high, moderate or low); Diabetes; Marital status; Living situation (living alone, etc.); Education; Income; Stroke; Hypertension; Arthritis; Respiratory diseases; Incontinence; Depression; and Prior/frequent hospital use (Gaugler et. al. 2007; Luppa, Luck, Weyerer, Konig, Brahler, & Riedel-Heller, 2009). In all, about twenty-four factors have been identified as determinants of institutional care facilities.

Meanwhile, from the meta-analysis of Luppa et al. (2009) of all international studies on determinants of institutional care facilities admission or utilisation, some of the determinants were reported to have strong and consistent evidences in literatures, few with moderate evidences, while others have weak or inconclusive evidences. According to Luppa et. al. (2009) justification for consistency or coherence of a factor was based on the continuous report of their significance in literature independently or as confounding factor. Factors considered to have strong evidences were those that have consistent findings in at least 75% of high quality studies of longitudinal, prospective and cross-sectional studies, moderate evidences are factors that have 75% consistent findings in at least two high quality studies, weak evidences are those found in one high quality study and inconclusive evidences are those found to be inconsistent in literature.

Most international studies on institutional care for the elderly reported varying degree effects of the determinants. While some studies underscored and ascribed significant relationships between some factors and institutional care, other studies have reported same inconsistent. For instance, many studies in the United States have underscored that income is an insignificant determinant of institutional care provided that confounding factors such as health is controlled for (Anderson & Newman, 1973; National Centre for Health Statistics, 2009). Whereas, studies in Germany (e.g. Klein & Salaske, 1994) reported the relative and composite effects of income as significant determinant of utilisation of the elderly institutional care facilities.

The implication of these shows that the significance of each factors may probably be based on the circumstantial peculiarity of the country or region where the study is carried out. Some countries particularly the developed ones who have structural arrangements for social security that takes care of the pecuniary need of the elderly may report insignificance of income as a predictor of utilisation of institutional care facilities among the elderly. However, countries or regions with no structural financial and social securities for the elderly may report income, particularly household income as a strong determinant. This is due to the fact that availability of the social security platforms might have taken care of the financial requirement and plausible consequences arising therefore, hence, it may appear insignificant.

From Luppa et. al. (2009) synthesis result, determinant factors that have strong evidences in literature are the age, ethnicity, house ownership, and health related factors, particularly the cognitive and functional impairments. Other diseases and illness such as arthritis, hypertension stroke, and diabetes have weak or inconclusive evidences. Few of the socioeconomic determinants have at best moderate evidences (employment status and social network) while many others have inconclusive evidences. Deductions from this study imply that about 50% of the determinants factors identified in literature have inconclusive evidences which underscore further research on the determinants factors that predisposes the elderly to the use of institutional care facilities.

Meanwhile, most of these studies reported in literature have been able to report the significance of one factor or the other based on the geographical frontier of the country or region where the report has been conducted, whereas, peculiarities of these countries or region may restrict the inferences of those research to be generalised on other region or country with different peculiarities. For instance, inferences on studies of determinants of the elderly' institutional care facilities carried out in other countries may practically be difficult to apply in Nigeria, as there are many confounding variables such as socioeconomic, political, ethno-cultural, and religious factors that are peculiar to Nigeria which may intervene in the research. An example of such on the use of old peoples' home in Nigeria is religion. Preliminary investigation revealed that religion may have a significant effect on the use of old peoples home in Nigeria, partly because the campaign on the use of institutional care for older person was primarily launched by the Catholic Mission in Nigeria. However,

Islamic indoctrinations in the country have not been favourably disposed to the utilisation of old peoples' home. These bring the necessity to undertake a research specifically in Nigeria, to understudy the determinants of utilisation of the elderly' institutional care facilities.

Furthermore, investigations in literature have presumably revealed the conditions of the elderly in Nigeria and their vulnerability to the utilisation of institutional care facilities though without concerted effort for empirical evidence. For instance, Wahab (2005) while examining the social and economic security of the elderly in southwestern Nigeria reported that the social and economic condition of the elderly in southwestern Nigeria is inadequate. He emphasised that ensuring security for the elderly could only be attained through the rejuvenation of the indigenous social welfare system which bothers majorly on the extended family structure since there is no formal structural care for the elderly in Nigeria. Though Wahab (2005) speculated that government is expected to make provisions for the social and economic security to for the elder through institutionalised structure of care, yet his studies drifted from justifying focus for the institutional care for the elderly.

Similarly, Aboaba (2003) argued that nutritional trend among the elderly in southwest Nigeria revealed that the major solution to nutritional deficiencies among the elderly in medical and health framework could be provided through institutional campaign in geriatrics that is focused on special nutritional programmes for the elderly. As such specialised institutional care for the elderly may help them with the needed calorie intake and nutritional value. Deductions from Aboaba (2003) indicated that the elderly who are residents of institutional care facilities may be assisted with regulated nutritional content in terms of what they consume since their they would, expectedly, receive a 24 hours care.

Further, from the deductions into Aikhoje (2006) when he studied the determinants of life satisfaction at retirement, the elderly who are less active as a result of physical, or psychological incapacity were less satisfied with life at retirement. However, when incapacity sets in the elderly could do little with their daily routine without help. This underscores the need for coordinated care for the elderly whose satisfactions with life have been reported to be inadequate which could be better achieved through institutional care.

Adedeji (2008) while comparing the indigenous social welfare practices for the old people among the Ewe of Ghana and the Yoruba of Nigeria reported a decline in the traditional social welfare systems that take care of the elderly among the Yoruba owing to the exponential rate of globalisation trend and the cultural diffusion syndrome among the tribe. Deductions from this study revealed the weakening of the extended family structure and the breakdown of family into individual units which is growing fast among the newer generations of the Yoruba race. This leaves the elderly to risk of loneliness and therefore exposes them to bigger risk of untimely death. Adedeji (2008) though has unravelled the quagmire of declining care for the elderly among the Yorubas, but his study did not provide a justification for a coordinated care in institutional facilities.

Unlike Adedeji (2008), Temilola (2010) in his study on poverty and wellbeing among the elderly in Iwo, southwestern Nigeria, advocated for adequate access to formal and informal socioeconomic strategies and health framework as the major antidote to the challenges of old age poverty and ill-health among the elderly. This position is anticipating an institutionalised framework that takes care of the social, economic and health challenges among the elderly. Though, the study lacks the clear insight and empirical basis for institutional care facility, majorly because it reported a higher level of poverty among the elderly which is not unconnected to their statuses of ill-health. However, the study did identify the need for institutional care despite the vacuum.

Omotayo (2015) in his study on socioeconomic factors and health statuses as determinants of life satisfaction among public service retirees reported large inadequacies in the social and economic conditions of the elderly who have retired and a deteriorating health status largely due to their inability to meet up with their pecuniary needs which hinges on the socioeconomic variables. The position of the study suggests concerted efforts in gerontology to better care for the challenges of the elderly through various institutions which cuts across the social, economy and health sector. This study however, has not articulated the structural need for institutional home care which may cater for the holistic need of the elderly and did not put into consideration the determinants for institutional care utilisation.

From the foregoing therefore, there have been quite a number of reports in literature that documented the social, economic and psychological circumstances of the elderly in Nigeria. Many have studied the elderly from the perspective of retirement challenges that are inextricable (Aikhoje, 2006; Abdullah, 2010; Oke, 2014; Omotayo, 2015; Nweke, 2015) as a result of old age, others have bothered on life satisfaction of the elderly (Amaike, 2006; Salami, 2010) while a handful have focused on wellbeing and socioeconomic challenges of old age (Wahab, 2005; Adedeji, 2008; Temilola, 2010; Atte, 2014).

Succinctly however, Studies from foreign countries on institutional care for older people have focused and identified the determinants of institutional care based on their unique socio-cultural values and domesticated the need for the care of the elderly as acceptable by their society. Anderson (1968) identified the factors of institutional care usage as predisposing, enabling and need factors, Anderson and Newman (1973), identified age, gender, family size, marital status, among others as individual determinants, while Arber and Ginn (1991) postulated resource triangle which comprise of health resource, material resources and caring resources. Other studies **(**Tomiak, Berthelot, Guimond, & Mustard, 2000; Grundy & Jitlal, 2007; DH, 2010; Einio, 2010; Fisher & Scragg, 2012;Wu, Hu, Huang, Fang, Chou, 2014**)** have attributed functional and cognitive impairments as the major factors that put the elderly at risk of institutional care. Though there are factors reported to have significant effect on the elderly' institutional care such as social class, age, house ownership, among others, yet there are weak or inconclusive evidences of their effect in literature either as independent or confounding factors. Other factors accounted for were income, lack of family care especially loss of spouse and housing conditions. Health-related factors such as distant (e.g., diseases, accidents) and proximate (e.g., functional and mental disabilities) categories are considered the primary determinant factors for utilisation of institutional care (Einio, 2010). These studies have not clearly provided clearer conceptual enumeration on other determinants of the provision of institutional care for the elderly rather it (provision) has mostly been seen as a reflex response to the need of the elderly arising from the understanding of the social circumstances. Whereas, as clearly noted above, these studies have focused only on the individual level determinant of the elderly institutional care as a response to the need of the elderly and do not consider factors that are not predominantly within the

socio-cultural context. For instance, these studies have clearly ignored the significance of factors such as religion, acceptability, disposition, legal framework among others which are plausible factors of concern for societies like Nigeria.

Therefore, there is need for research on institutional care for the elderly particularly while focusing on the individual level of determining factors that may predispose the elderly in Nigeria to the risk of utilisation of institutional care facilities. This study therefore focuses on the determinants factors that predisposes the elderly in south west Nigeria to utilisation of institutional care facilities.

2.3 Theoretical Framework

The relevant theories used for this study are majorly theories of social gerontology which explain issues concerning the elderly, how to relate with and care for them. This segment of the research expatiates on some of these theories in explaining scholars' position on how individuals cope with situations brought about by age. This is necessary because according to Bengtson, Tonya, and Burgess (1996), theory provides a guide for investigation and predicts what is unknown. The following are discussed.

2.3.1 Activity Theory

From the submission of Havighurist (1968), theory explains the mechanism for older person to age gracefully within the confines of their socioeconomic environment without losing their grip and influence. Furthermore, theory represents a normative view of aging; that individuals in order to age well must maintain social role and interaction, rather than disengage totally from social life (Morgan and Kunkle, 2001). From the position of Lemon, Vern and James (1972), the essence of theory is that there is a positive relationship between activity and adaptation to life at old age. Theory further explains that for older person to enjoy old age, they must be engaged in activities that are favourable to their condition and places them at advantage to enjoy life. If circumstances do not permit them, they should rather find a replacement for the socioeconomic and physical environment that conditioned them to a regimented and unfulfilled life. Theory brings into focus and help in understanding activities the elderly may engage in for optimal living and determinants to be considered in living optimally which arrangement is catered for in institutional care.

However, theory lacks detailed explanations on the influence of the social and physical environment on the aging process.

2.3.2 Ecological Theory

Ecological theory of ageing as explained by Lawton (1989) explains that the competence of the elderly to function effectively largely depends on the conditions of his social and physical environment. The physical and environmental conditions of living of an older person play significant role in his adaptations and optimal living. This implies that living arrangements, housing condition, social class among other may be plausible determinants in the optimal wellbeing of the old people. Perhaps the social and physical environment of the older person is occasioned by inadequacies; the wellbeing of such person may consequentially be less optimal. Theory expatiates on the influence social and physical environment has on the functional status of older person. It states further that the environment's influence increases as the functional status of the elderly decreases. Therefore, an interaction between personal competence and social and economic conditions will determine the extent to which an older person will live optimally. This theory implies an ideal and comfortable social and physical environment for older person which is expected to underscore adequate care for them. However, a reverse in such circumstance may result in poor adaptation and survival for older person.

This theory explains the basis for the socioeconomic determinants of utilisation of the elderly institutional care. When living arrangement and housing condition for instance do not produce relative comfort and care for older person, such situation may occasion the utilisation of institutional care where expectedly the favourable social and physical environment would be provided for the wellbeing of the elderly. whereas, the theory failed to underscore the human indices in the environment that will give support to the older person for their graceful ageing.

2.3.3 Family Support Theory

According to Lingsom (1997), care giving by family member to their older person may be cumbersome and challenging largely due to the dual earners' family syndrome and the weakening of the extended family structure. Therefore, it becomes imperative for the formal services system to strengthen the family care by sharing the burden of care giving. This position articulated the need for institutional care arrangement for older person to cater to the diminishing role of family member in the

care and management of their elderly. Although theory does not shift the burden of care entirety from the family, it still emphasises on the role of the family members in taking care of the pecuniary needs of the elderly such as payment of the institutions' bill among many other. Theory suggests a fundamental basis for family as determinants of utilisation of institutional care among older person.

2.3.4 Relevance of theories to the study

Each theory has emphasised different aspects of ageing in relation to the study in order to understand the whole. Therefore, this segment of the research harmonizes all theories as they interlink with the variables in relation to the research. Activity theory explains the reason why the elderly should remain active to escape challenges of old age which is occasioned by socioeconomic and health incapacity that the institutional care is likely address. Ecological theory comes into the study to explain the significance of social and physical environment where the elderly live as determinants of their optimal living and presumed that plausible dysfunction may arise from uncomfortable and undesirable social and physical environment. Family support theory brings to consciousness the weakness in the family system to provide holistic care for the elderly and therefore suggests a formal arrangement of care in institutionalise pattern for older person that would put their socio-cultural needs into consideration and lift the burden of care off the family members.

Meanwhile, the pivot of theories is family support theory though linked to other theories. Family support theory explains situations that warrant the need for old people's home. The theory expatiates circumstances that have necessitated the need for some the elderly to reside in old people's homes as the alternate arrangement to care for the elderly to cushion the effect of weakened family system. Demographic factors and weakened family structure owing to urbanisation are justified by the family support theory and inability to cope with dictates of the social and physical environment as conceptualised in the socioeconomic factors were strongly supported by the ecological theory of ageing. Consequently, the elderly have to remain active by substituting former roles and relationships for new ones as expatiated by activity theory.

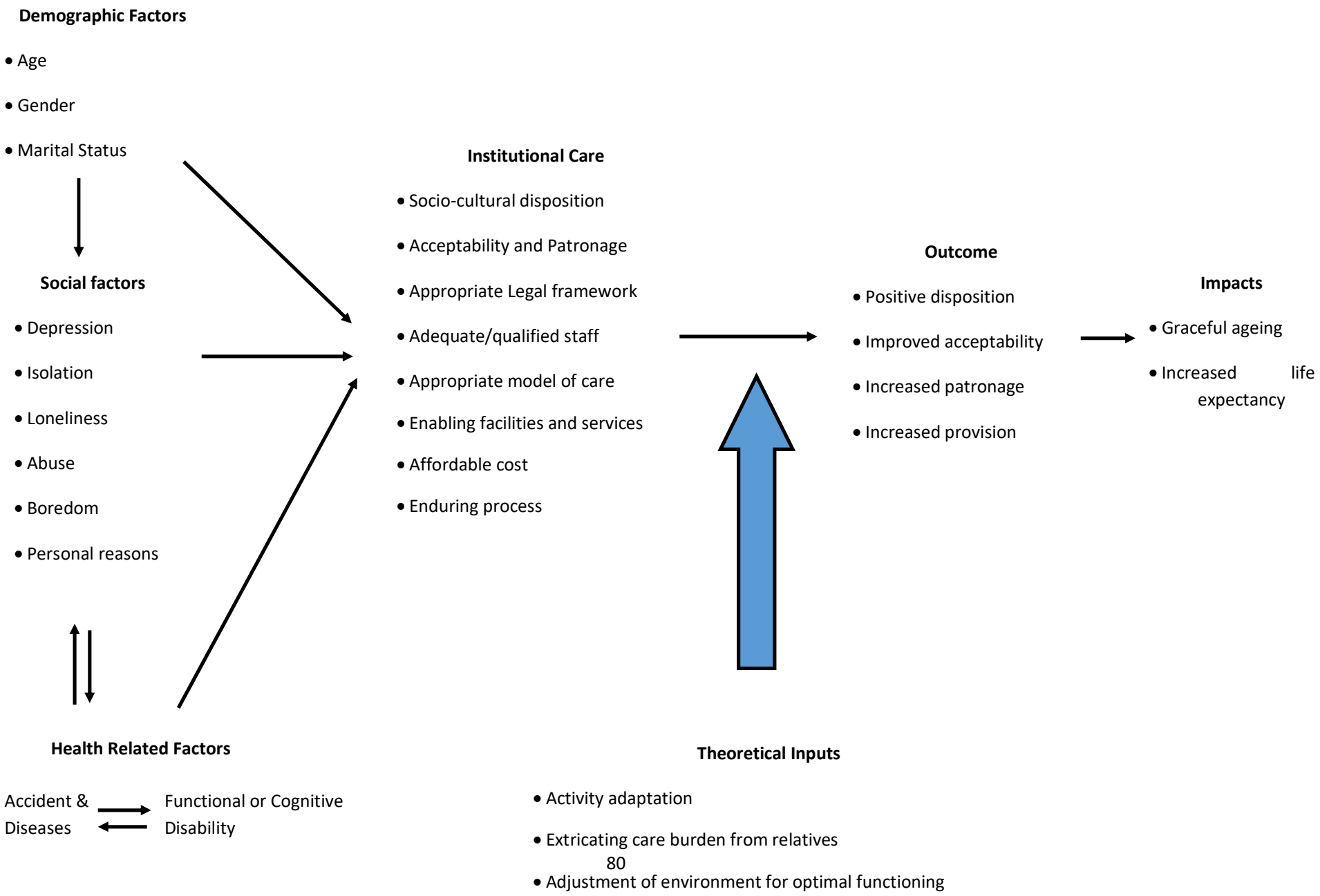
Subsequently, the researcher will be considering the extent to which it will address the well-being of the elderly which may influence their usage of institutional care facilities such as old people's home. The framework therefore presumed that

various determinants factors interacting with the elderly may influence the provision and consequently the utilization of institutional care.

2.3.6 Model for the understanding of key variables related to institutional care facilities provision for older person

Demographic factors are presumed to be more distant determinant for the provision of institutional care largely because old age naturally comes with challenges of functional incapacity owing to wear and tear of the body. Gender and marital status may also independently determine institutional care. While controlling for other factors, socio-demographic factors over spade of long time may be consequential determinants of institutional care among older persons. Meanwhile, while considering other factors, Social factors such as depression, loneliness, abuse, isolation among others may be well thought-out to have interaction and complimentary relationship with Demographic factors that may further determine the institutional care for the elderly. These complimentary effects stress the preponderance of effects such as the societal disposition to institutional care facilities, acceptability to the facility, religious beliefs on the use of the facilities and family influence and their socio-cultural perception to institutional care. This is because the decision to use an institutional care facility may largely depend on the family coherence (in structure and size) and the support system that is available within and without the family, the companionship that would be availed the older person, which perhaps may not be available largely due to the societal changes in values, and the quality of care to be enjoyed at such facility.

Fig, 1: Key variables related to institution care provisions for the elderly



Further, factors determining provision of institutional care facilities are pivoted by health-related factors because of their significance link as determinants of provision of institutional care. Presumably, if the older person suffers health incapacity, which of course is inversely proportional to institutional care (Fig 1), the decision to use institutional can therefore not be independent which may be revolved around certain social and demographic variables. Paradoxically, interactions of demographic variables with the elderly institutional care facilities provision, independently of other factors, may hinder the functional capacity of the elderly, which may also abuse the need to provide institutional care for them. Until it is further proven empirically, it is therefore incoherence to conclude that demographic variables are individuals level determinants to the use of institutional care.

Apparently, the two intervening variables that may affect the interaction between the social factors and provision of institutional care facilities for the elderly are the demographic factors and health related factors. Health incapacities may remain constant determinant to institutional care, the very reason it becomes contiguous in the model. Conversely, demographic factors as shown in the model (Fig. 1) are more remote determinants but are also interrelated to all other factors.

2.4 Appraisal of Literature Review

The study reviewed literature as it concerns the elderly and their institutional care. It begins with the review of social welfare practice with the elderly which form the basis of social gerontology. It traces the history of social welfare for the elderly and identified the major means of care for the elderly in literature which basically hinges on residual and institutional care practices. The study further dwells on the means meeting the elderly need that could be found in literature that culminated into six categories which include; mutual aid; charity philanthropy; public welfare; social insurance; social services; universal and universal provision. This review revealed the general concept of the elderly; care for older person; institutional care facilities in the southwest Nigeria; legal provision for the establishment of institutional care facilities in Nigeria; provision and utilisation of institutional care that is available in literature.

The study examined the concept of institutional care for the elderly. It traces the history of institutional care for the elderly to the alms-houses and public poor houses of colonial America and identified forms of institutional care as residential in-home service which provide short- and long-term care for the elderly. It further identified the various forms

of institutions that provide relative care for old people such as old peoples' homes, nursing homes and hospices. The review discovers in sum that institutional care for older person is all form of organised or special arrangements, which include residential care that caters for the need of the elderly.

The determinants of provision and utilisation of the elderly institutional care were also thoroughly reviewed by this study. Many positions were discovered in literature which include the earlier studies of Townsend (1962) which identified socioeconomic and environmental factors that hinges on the activities of self-care as the major determinants of utilisation of institutional care, Anderson (1968) that postulated the predisposing, enabling and need factors, Arber and Ginn (1991) that categorised the resources that determined the utilisation of institutional care into health, materials and caring resources, to the most recent (e.g. Einio, 2010; Wu et. al., 2014) that identified other factors such as housing conditions, living arrangement and possession of a car.

The study further explored the identified determinants of provision and utilisation of the elderly institutional care facilities such as age, gender, marital status, family structure and size, bereavement, bareness, income, housing condition, education living arrangements, religions, and access to informal carers among others and their significant effects in literature. It further examined the other concepts relating to the elderly utilisation of institutional care facilities such as long-term care, prevalent long-term conditions, ageing and ageism, global ageing and contemporary issues, stereotypes, discrimination, loneliness, depression, mental health, nutrition among many other concepts relating to older person's utilisation of institutional care facilities.

The empirical review conducted by this study revealed that studies on socio-cultural factors and institutional care facilities provision have been conducted based on national population of the elderly or regional based through longitudinal or cross-sectional studies, mostly in foreign countries. The review identified wide variation in the reports of different studies across courtiers and regions. While some factors were reported significant in some countries, they become insignificant in others. This was identified by the study as a result of methodological differences, peculiarities of the area and population of the study. The study further identified that despite the noticeable variations, some factors were found with consistent report having strong evidences in literature while a host of others are with moderate, weak or inconclusive evidences as the case may be.

Having examined the different conceptual models available in literature, the study developed a reformulated model, which puts into consciousness the presumable factors that may be peculiar to the population under the study. Finally, to provide theoretical justification for the study, the study adopted exclusive theories of social gerontology that relate to utilisation of institutional care for the elderly and synchronises them with the variables under study.

CHAPTER THREE
METHODOLOGY

The chapter describes the procedure used in carrying out this study. It covers the research design, population and sample. It also includes data collection and methods of data analysis. The methodology for this study will reflect the use of appropriate quantitative and qualitative methods of data collection, analysis and interpretations.

3.1 Research Design

The descriptive survey design was adopted for this study. This is because it helped in a systematic manner to describe the characteristics of variables and relationship that exist between the variables under study. However, since the study did not manipulate any variable, the study, therefore used descriptive design to give an accurate account of characteristics of the elderly and the variables under study.

3.2 Study population

The population for this study included all the elderly who are residents and outpatients of the institutional care facilities, family members responsible for their care and the care providers in these facilities in southwestern Nigeria.

3.3 Sample and Sampling Techniques

A total number of two hundred and sixty-four (264) residents and outpatients of institutional care facilities that met the sampling criteria were selected. The study adopted a multi-stage sampling procedure. First, it adopted the purposive sampling technique to choose the three states (Lagos, Ogun and Oyo) with high number of institutional care facilities for the elderly in southwestern Nigeria. Second, it used a total enumeration of the entire the twenty (20) institutional care facilities available in the selected states as at the time of the study, which include both private, and government owned facilities. Third, it adopted purposive sampling technique to select the elderly that meet the inclusion criteria. Fourth, accidental sampling technique was used to sample the professional caregivers accessible during the period of the study as all the staff were not always on duty at all times and lastly, snowballing sampling technique was used to sample the family members of the elderly responsible for their care.

3.3.1 Inclusion criteria

The inclusion criteria are the basis for the purposive selection of the respondents. This is criteria is set for this study to select the most appropriate respondents who fit directly into the category that will provide useful and appropriate responses for the study. The inclusion criteria for the purposive sampling of the residents of the institutional care facilities include:

1. Residents of institutional care who have not spent more than one year in the facilities
2. Residents with sound mind and relatively fair cognitive ability.
3. Residents with capacity to consent.

Table 3.1: Number of Institutional care facilities for the elderly in Southwest Nigeria

SN	STATE	NAME OF INSTITUTION	ADDRESS
1.	Lagos	1. The Old Peoples' Homes	Birrel Avenue, Yaba Lagos
		2. Regina Mundi Home for the Elderly	142/144 Agege Motor road, Mushin Lagos
		3. Winiseph Care Home	326, Adeyemo Akapo street, Ikeja Lagos
		4. Rockgarden Homes	191/193 Okeletu-ijede road, Elemu bus stop, Ikorodu, Lagos
		5. Wellcare Home	65, Rasaq Balogun Street, off Adebola Street, off Adeniran Ogunsanya street, Surulere, Lagos.
		6. Alpha Nursing agency	38, Oyewole Street, off shyllon street Ilupeju, Lagos
		7. Miradora Care Homes	24, Ibironke crescent, Maryland, Lagos
		8. Bluegate Care Agency	17, Morowofolu street Akoka, Lagos
		9. Beautiful Angels	13, Olasanoye street, Ijegun-Egba, Amuwo-Odofin, Lagos.
		10. Family Ark Mission Agency for the Aged	Family Ark Mission Center, Ikeja, Lagos.
		11. Regal Care Nig. Limited	57, Odozie Street, Ojodu, Lagos.
2.	Ogun	1. Pro-Laborde Elderly Home	Ijebu Ife
		2. Live on Old Peoples Home	Km 40, Lagos-Ibadan Express way, Maba, Obafemi Owode, Ogun State.
		3. Gideon Home for the Aged	31, Adegboyega street, Asero Housing Estate, Abeokuta.
3.	Oyo	1. Rossetti Care	Wahab Olayiwola layout, Tose Moniya, Ibadan
		2. Divine Senior Citizen	Palace PDCOS Estate, Akobo, Ibadan
		3. Emmanuel Alayande Rehabilitation Center	Awotunde Estate Elekuro, off Olorunde Aaba road, Ibadan
		4. Vineyard of Grace Home Health Care Agency	24, Kudeti Avenue, Onireke, Ibadan, Oyo State.
		5. Tony Anenih Geriatric Center	University College Hospital, Ibadan.
		6. Assisted living Homecares Limited	36, Alaafin Avenue, Oluyole Estate, Ibadan.

Source: Preliminary survey, 2016

3.4 Instrumentation

Data for this study were collected through the use of questionnaire, interview schedules and focus group discussions. The questionnaire was the main instrument used to collect data for this study. The questionnaire was administered to the elderly. Trained research assistants were employed to administer the questionnaire to the respondents in order to assist them with the options of the instrument in part and to interpret the content of the instrument peradventure there is a language and comprehension problem.

This study also conducted focus group discussions with the elderly. One FGD comprising about five or six (as the case may be) older persons in each group was conducted in each of the ten (10) facilities selected. The discussions were based on the major themes identified in the objectives of the study. Key Informant interview was also used to collect data for this study. A total number of 28 telephone interviews were conducted with family members of the residents. IDI was conducted with the professional caregivers in the institutional care facilities. One interview was conducted in each of the facility to elicit information for the study.

3.4.1 Questionnaire

1. The questionnaire tagged "Institutional Care Facility Provision Questionnaire" is a self-structured instrument which has two sections. Section A bothers on the Socio-demographic determinants of institutional care. This section has multiple option response scale. While section B focuses on the issues of provision of institutional care facilities. It contains items that are used to measure the socio-cultural factors and provision of institutional care facilities such as disposition, accessibility, Quality of care, companionship, religion, care practice, staff resources, services and facilities, and utilisation. It is designed on a two scale of 'Yes' and 'No' in order to make the questionnaire items less cumbersome for the frail older person. The instrument only collects basic information relating to the subscales and each item has a unique purpose. The content of the Questionnaire was validated through subjection to criticisms and analysis of the psychometric properties of the items. Meanwhile, the reliability of the scale was ensured through a pilot study that was conducted on ten (10) residents of Pope John Paul II Home for older person at 74 Target Road, Calabar, Cross Rivers State. This was done using a test and re-test reliability and the coefficient value of r =0.742, p= 0.02 using Pearson product moment correlation statistics.
2. Standardized inventory on Institutional care facilities developed by Murphy, O'shea, Cooney, Shiel, and Hodgin (2006) was adapted for this study. The questionnaire was

used to elicit responses on the capacity of the existing institutional care facilities in southwestern Nigeria. The items of the questionnaire have multi answers, which have been allotted corresponding numerical ranking for easy analysis. The reliability of the scale was also ensured through a pilot study that was conducted on ten (10) residents of Pope John Paul II Home for older person at 74 Target Road, Calabar, Cross Rivers State. A test and re-test reliability coefficient value of ($r = 0.729$, $p = 0.02$) was obtained using Pearson product moment correlation statistics.

3.4.2 Focus Group Discussion Guide

The focus group discussion guide was developed to elicit responses from the elderly who are residents of the institutional care facilities. This is necessary to compliment the basic data gathered with the questionnaire and to answer salient questions that the questionnaire would leave unanswered. The FGD guide has various modules, which include items on factors of provision of institutional care. The guide was subjected to correction and criticisms for validity. The focus group discussions were conducted in ten facilities and the participants that were involved in each session ranges between five and six. The subthemes of the FGD guide include: socio-cultural disposition, acceptability, patronage, process of care, cost, meaningful activities, services and facilities among others.

Table 3.2 Focus group discussion schedule

Group	Venue	Date	Number of participants	Number of session
FGD 1	The Old Peoples' Homes	25/07/2018	06	01
FGD 2	Regina Mundi Home for the Elderly	26/07/2018	05	01
FGD 3	Rockgarden Homes	26/07/2018	06	01
FGD 4	Wellcare Home	28/07/2018	06	01
FGD 5	Live on Old Peoples Home	29/07/2018	06	01
FGD 6	Gideon Home for the Aged	02/08/2018	06	01
FGD 7	Divine Senior Citizen	04/08/2018	06	01
FGD 8	Miradora Care Homes	12/08/2018	05	01
FGD 9	Winiseph Care Home	16/08/2018	06	01
FGD 10	Beautiful Angels	28/08/2018	05	01

3.4.3 Key-Informant Interview

The Key-informant interview schedule guide was designed to elicit information from the family members of the resident particularly on the perception to the use of the facilities, socio-cultural dispositions, acceptability, and costs of care among others. The family members responsible for the care of the elderly were contacted through telephone calls under the supervision of the administrators of the homes. Twenty-eight (28) sessions were conducted under closed ethical guidance with the consent of the elderly. However, not all residents consented to this. The family members were duly informed that the interviews would be recorded and documented for research purposes and voice consents were obtained. The interview schedule guide had the following subthemes: disposition, acceptability, process and quality of care, cost, and relationship with friends and family among others.

3.4.4 In-depth Interview schedule

In-depth interview were conducted with leading questions on the objectives of the study as they concern the institutional care provisions for the elderly. The schedule is subdivided into major sub-themes such as socio-cultural disposition, acceptability, institutional capacity, trend and motive of establishment, level of utilisation, and quality of care, among others. The staff of the facilities particularly, the heads of the care provider available when the study was conducted were interviewed.

Table 3.3 In-depth interview schedule

Group	Venue	Date	Number of participants	Number of session
IDI 1	The Old Peoples' Homes	25/07/2018	01	01
IDI 2	Regina Mundi Home for the Elderly	26/07/2018	01	01
IDI 3	Rockgarden Homes	26/07/2018	01	01
IDI 4	Wellcare Home	28/07/2018	01	01
IDI 5	Live on Old Peoples Home	29/07/2018	01	01
IDI 6	Gideon Home for the Aged	02/08/2018	01	01
IDI 7	Divine Senior Citizen	04/08/2018	01	01
IDI 8	Miradora Care Homes	12/08/2018	01	01
IDI 9	Winiseph Care Home	16/08/2018	01	01
IDI 10	Beautiful Angels	28/08/2018	01	01

Table 3.4: Data collection matrix by objectives

Objectives	Questionnaire	FGD	KII/IDI
Objective 1		√	√
Objective 2			√
Objective 3		√	√
Objective 4	√	√	
Objective 5	√	√	√
Objective 6		√	√
Objective 7	√	√	√
Objective 8		√	√

3.5 Procedure for Data Collection

To avoid breach of ethical guidelines, the study obtained ethical approval from the University of Ibadan Social Science and Humanities Research Ethics Committee before proceeding to the field. Actual visits were made to all the institutional care facilities for the elderly in southwest Nigeria. Questionnaires were administered to the elderly who are residents or outpatients in the facilities. Participants were required to answer the items of the questionnaire. Trained Research Assistants assisted the participants in completing the questionnaire. Focus Group Discussions were also conducted with participants to elicit further responses that might not have been addressed in the questionnaire. Participants were in a group of five and six and participated freely in the discussion groups. Questionnaire and interviews were also administered for the professional care providers in each facility. The family care givers (relative(s) of the older person(s) who is/are responsible for their care) were also interviewed through a telephone contact. The caregivers were contacted on the telephone and briefed on the purpose of the research after which the interview was conducted accordingly.

3.6 Method of Data Analysis

The data were analysed using qualitative, descriptive and quantitative analysis. Qualitative analysis was conducted to give critical content analysis of the interviews and the FGD. This is because the variables under study have been categorised into various themes under which the discussion were premised. On the other hand, descriptive statistical analysis of data were conducted to yield charts, percentages of frequency counts to analyse the questionnaire and logistics regression analysis was also adopted.

3.7 Ethical Consideration

The process of data collection for the study was guided by ethical principles that apply to human subject.

Confidentiality: All the responses that were given by respondents will be handled confidentially. The researcher shall not disclose any information obtained in the process of this study to anyone for any reason whatsoever.

Translation of protocol to local language: Language was also a criterion that was considered. This implies that the researcher made sure that all respondents selected understood and could speak well the language that was used in moderation. The instrument was translated to Yoruba language where necessary.

Beneficence: The researcher is duty bound to maximize the benefit, which is value added to the health and welfare of individuals, groups and society as a whole. The researcher ensured that the study avoided or reduced harms to the participants.

No harm to participant/respondent: This protects the respondents from any harm or abuse whatsoever. In the conduct of the study, the researcher ensured that no harm came to the respondents during the research or as a consequence of it.

Voluntariness: Participation of respondents in the study was voluntary. Written and verbal informed consents were obtained for voluntary participation in the study. This was necessary because the consent will serve as evidence that the process actually took place and respondents gave authorization to be involved in the study. Meanwhile the respondents were free to refuse to participate and withdraw from the study at any point without penalty or punishment.

Capacity of Respondents to Consent

The researcher measured the capacity to consent of the elderly and their caregivers by giving a brief education about the focus and objectives of the study. Also, the assessment consisted of two components.

Firstly, the elderly within the ages of 60 years above and their care-giver were recruited for the study. The researcher briefly interviewed the potential participants to determine whether they were competent. This was judged by their ability to understand and discuss their understanding about the scope of the study, in terms of psycho-education intervention, coping with burden of institutional care and to identify an appropriate surrogate where necessary. Respondents were purposively selected from the facilities.

CHAPTER FOUR

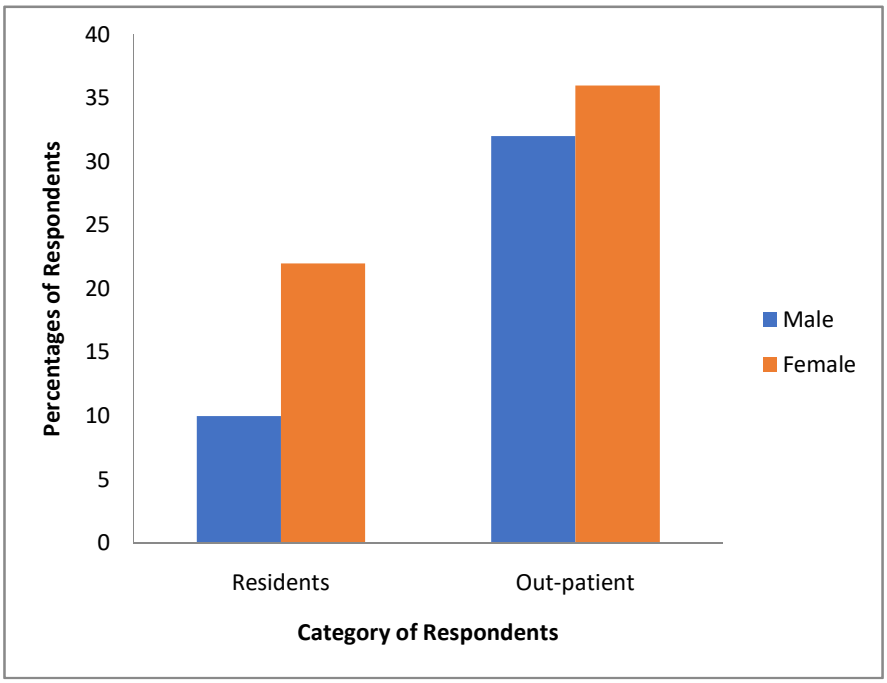
RESULTS AND DISCUSSIONS

This chapter presents the results obtained from the analyses of data collected for the study. This is aimed at addressing the research questions as they were stated in previous chapters. Results are presented in accordance with the ordering of the research questions used for the study.

4.1 Presentation of Demographic Characteristics of Respondents and Analysis

Figure 4.1.1 below shows the distribution of the respondents based on sex disaggregated by their use of institutional care facilities. The residents' category includes the elderly who live in the institutional care facilities and the outpatients were the elderly who visits the facilities occasionally based on need. The figure shows that 32% of the respondents are residents of the institutional care facilities while 68% are outpatients. The figure further shows that out of the respondents who are residents, 10% were male while 22% were female. Meanwhile, for the outpatients, 32% were male while 36% were female. Cumulatively, the respondents' distribution for male was 42% while female was 58%. This simply implies that there were more female respondents than male.

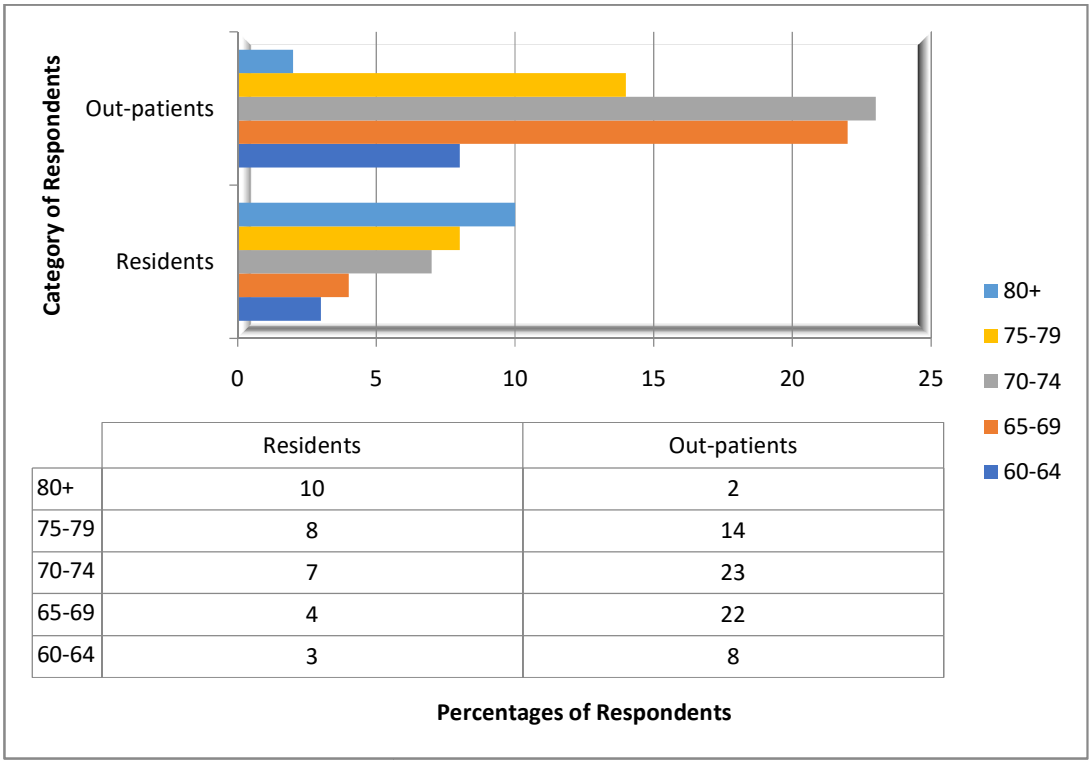
Figure



4.1.1 Distributions of Respondents based on Sex

Figure 4.1.2 shows the age distribution of the respondents ranging from group of 60-64 years, 65-69 years, 70-74 years, 75-79years to 80 years and above. The figure reveals that 11% of the respondents fall between the ages of 60 – 64 years with only 3% of them resides in the facilities while 8% were out-patients. 26% of the respondents fall within the age range of 65 – 69 years with only 4% of them resident in the facilities and 22% were outpatients, about 30% falls between the ages of 70 – 74 years with only 7% residents in the facilities and 23% were outpatients, 22% of the respondents fall between the ages of 75 – 79 years with only 8% resident in the facilities while 14% were outpatients, and 12% of the respondents fall between the ages of 80 years and above and 10% out of the 12% were residents of the facilities while the remaining 2% were outpatients.

Implications of the above shows that the age distribution that is mostly represented in the study are the elderly between the ages of 70 – 74 years. It further shows that most of the respondents at this age were outpatients. The figure also revealed that the elderly between the ages of 80 years and above were mostly residents of the facilities than outpatients.



	Residents	Out-patients
80+	10	2
75-79	8	14
70-74	7	23
65-69	4	22
60-64	3	8

Figure 4.1.2 Distributions of Respondents based on Age

Figure 4.1.3 revealed that 9% of the respondents were married and 4% were cohabiting and these respondents only fall within the category of outpatients. None of the respondents that were residents of the facilities was neither married nor cohabiting. 21% of the respondents were separated and only 6% out of them were residents of the facilities. 24% of the respondents were divorced and only 7% out of them were residents of the facilities and 42% of the respondents were widowed and 19% out of them were residents of the institutional care facilities. It is therefore suffice to infer that most users of institutional care facilities have marital status of either separated, divorced or widowed with very many of them in the widowed category. Further, it can be deduced that most of the residents of the care facilities were either separated, divorced and widowed and none of them is married. Whereas, married respondents were found among the outpatients in these facilities. These may imply that elderly persons who are married have preferences for outpatient care.

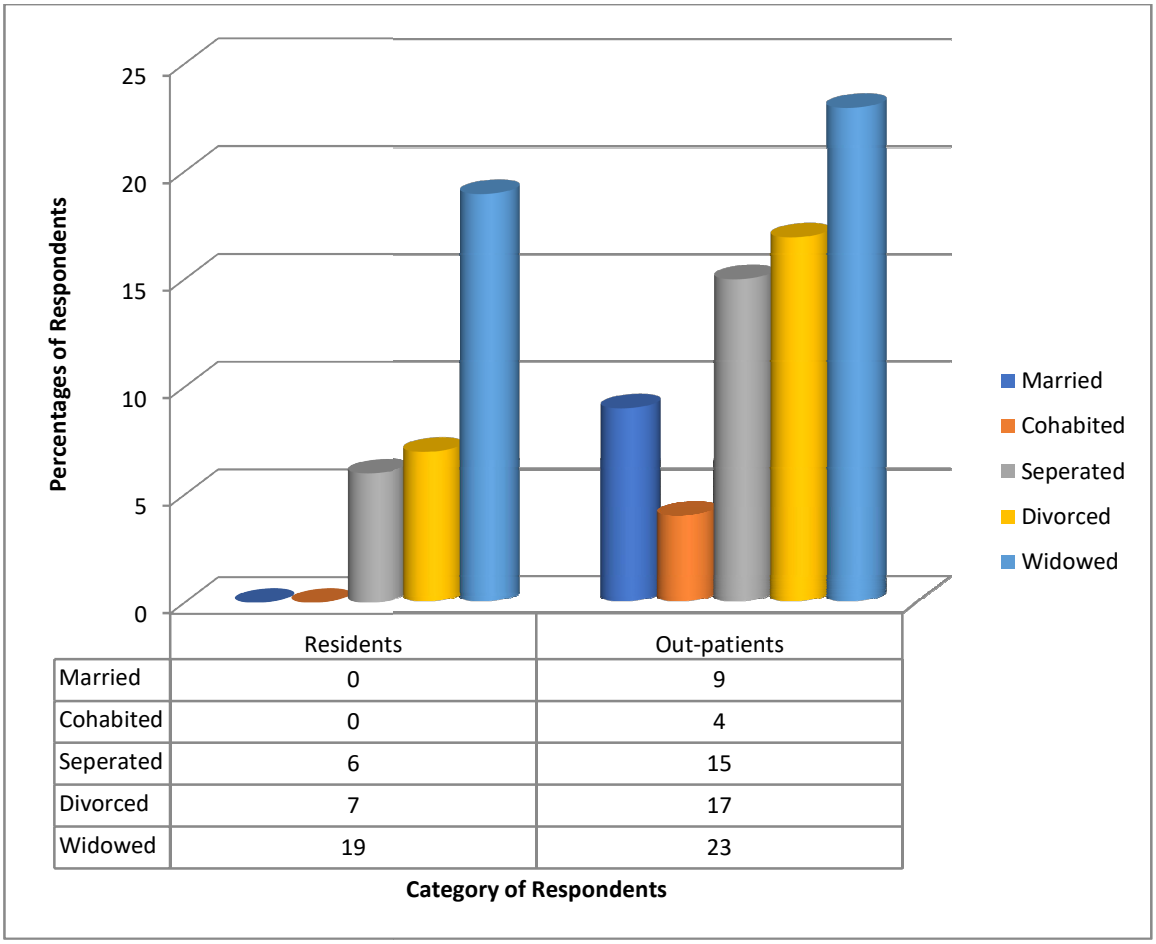
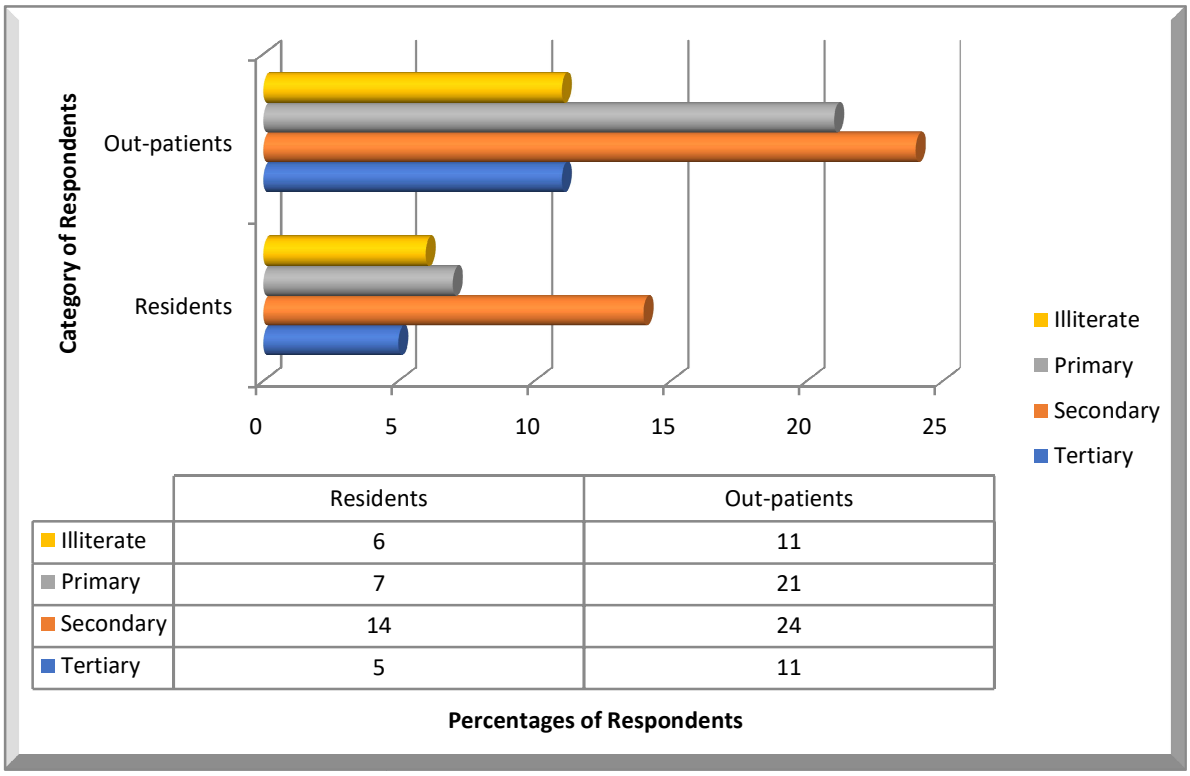


Figure 4.1.3 Distribution of Respondents based on Marital Status

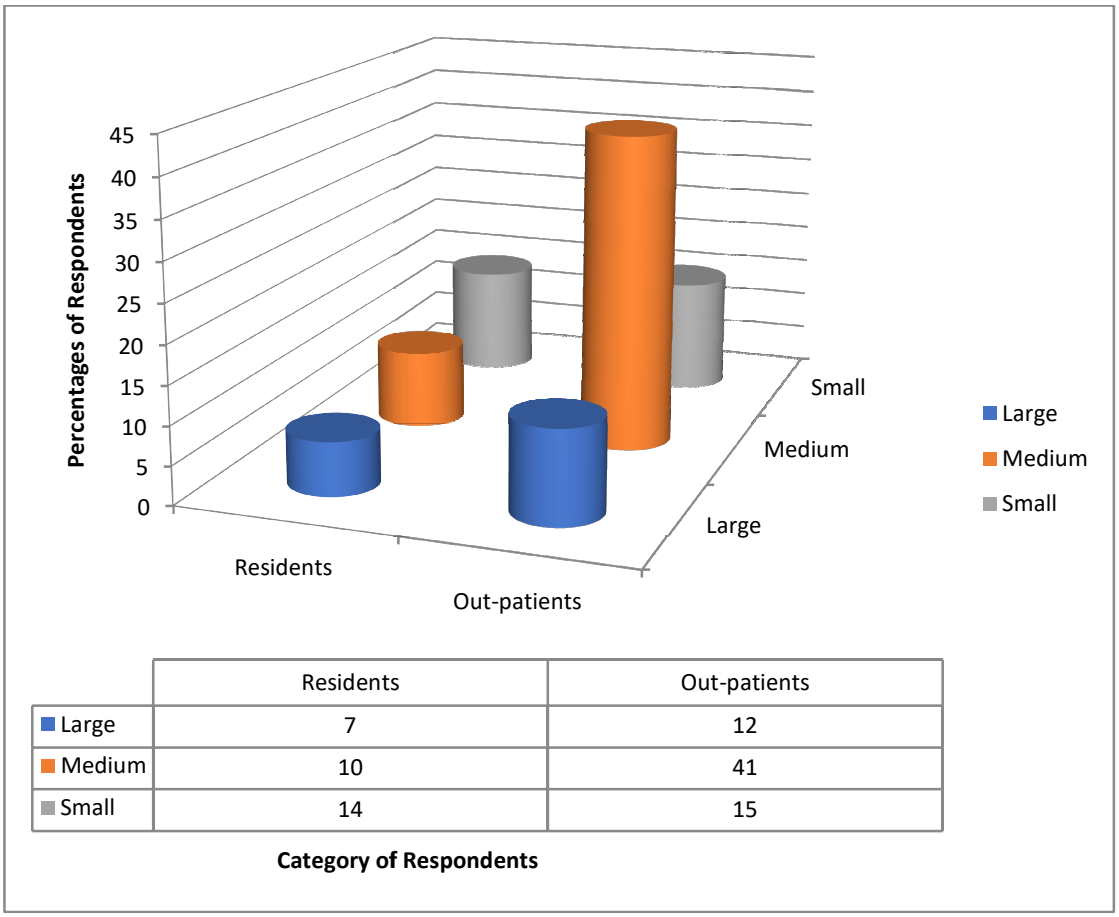
Figure 4.1.4 revealed that 17% of the respondents were illiterates with about 6% out of them living in the facilities while 11% were outpatients, 28% of the respondents had primary school level of education with only 7% out of them residing in the facilities, 38% of the respondents had secondary school level of education with about 14% of them residing in the facilities and 16% of the respondents had tertiary level of education with about 5% out of them residing in the institutional facilities. The data revealed that most of the respondents had an average level of education, which is the secondary school level, and this moderately shows that the distribution of the respondents is averagely literate. This imperatively shows that level of education may simply have little or no effect on the choice of utilisation of institutional care facilities for the elderly.



	Residents	Out-patients
Illiterate	6	11
Primary	7	21
Secondary	14	24
Tertiary	5	11

Figure 4.1.4 Distribution of Respondents based on Level of Education

Figure 4.1.5 shows that 19% of the respondents had a large family size with 7% out of them resident in the facilities. 51% of the respondents had a medium family size and only about 10% of them live in the institutional care facilities. While 29% of the respondents had a small family size and 14% out of them were residents of the care facilities. The implication here is that majority of the respondents had a medium family size and many of these respondents were outpatients. Meanwhile, those with small family size comparatively reside more in the care facilities. It is also instructive to note that families with less than or equal to five (≤ 5) members are categorised as small, families with member not less than six (6) and not greater than eight (8) are categorised as medium while families with members greater than or equal to nine (≥ 9) are categorised as large families. Imperatively, large family size is gradually weaning off in our socio-cultural setting and this is evident in the Figure 4.1.5below.



	Residents	Out-patients
Large	7	12
Medium	10	41
Small	14	15

Figure 4.1.5 Distribution of the Respondents based on Family size

Figure 4.1.6 revealed that 39% of the respondents were Muslims with only about 2% out them resident in the institutional care facilities while the remaining 37% were outpatients. It further shows that 61% of the respondents were Christians with about 30% of them residing in the institutional care facilities. This simply implies that most of the respondents of the study were Christians and imperatively most users of institutional care facilities were Christians.

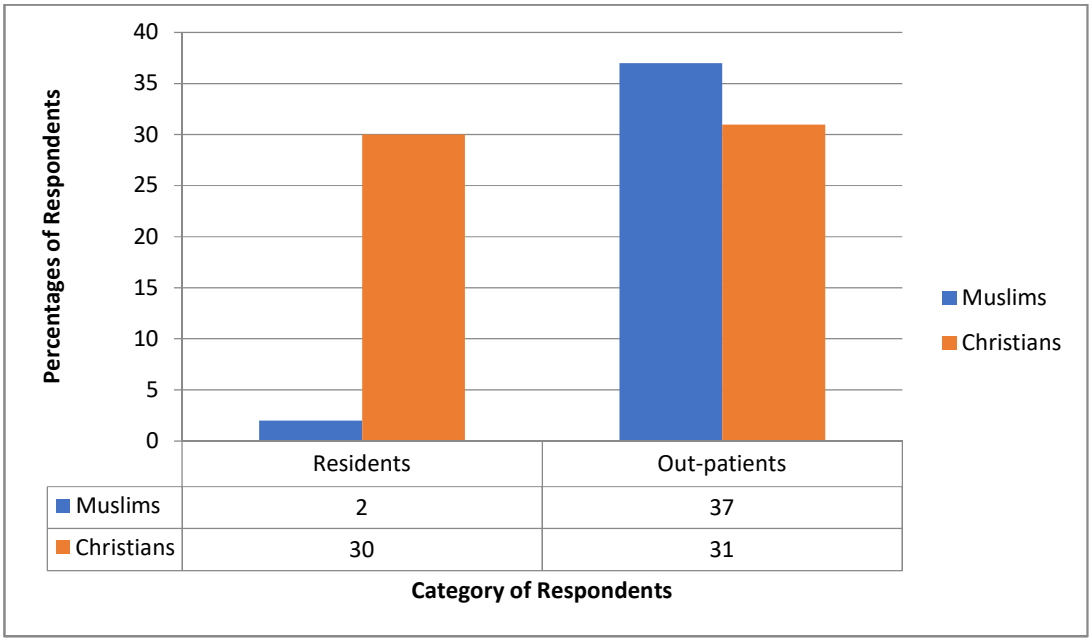


Figure 4.1.6 Distribution of Respondents based on Religion

4.2 Analysis of Research Questions

Research Question one: What is the socio-cultural disposition and acceptability of institutional care for the elderly?

The disposition to institutional care facilities for the elderly in southwest Nigeria is multi-dimensional as there are varying perspectives to it. Views explored by the study show individualistic perspectives, which cannot be generalized as the complete societal perception. However, an observed societal blithe among people on views seems to bother on the social fabrics, value and norms. There is an observed carefree attitude on what the society thinks, rather, individuals dwell on the issue as it affects them and their immediate families. Meanwhile, it is clear that those who are not directly involved in the care of the elderly are the ones who assume inadvertently in the figment of their imaginations that the society still condemns the use of institutional care facilitates by the elderly.

The Nigerian socio-cultural value from the three major ethnic groups does not historically supports institutional residence for the elderly and a trace of this is still found in the perception of expressions gathered by this study. This is evident in the perceptions of respondents among the caregivers. When asked about the perception and reaction of the society about placing their the elderly in the institutional care facilities, many of the respondents expressed the criticism they have received from friends and associates about the use of institutional care facilities. A respondent commented:

> The Igbo community is culturally sensitive. The tradition expects every individual to build a country home in their village(s) so that when they grow old, they will retire there with either immediate family members to care for them…so when you now for one reason or the other have to live in homes like this, you are considered unfortunate or a failure. Unfortunately, there are conditions that may coerce one to this circumstance. (KII 03, 26/07/2018).

The study observedin the psyche ofthe elderly(particularly the Igbos) onthe importance they placed on building a house in their village(s) and retire there before s/he dies as culturally demanded in Igbo culture. Another respondent commented on the criticism of the society and cultural perception of institutional facility use thus:

> since we took Mama to that facility, we had received few criticisms from some close relatives and friends. She has three children and all of us stay overseas and it is a little bit difficult for us to secure residence for her here abroad. Unfortunate those few relative and friends who continue to abuse us for the use of the facility are not ready to take her in and care for her, even though they have continued to abuse us, what option do we have? (KII 09, 16/08/2018).

Another respondent speaks:

> As a well-bred Yoruba man, I understand our culture emphasized that old parents are the responsibilities of their children and until very recently it has been so. But the world is evolving and we have to find solutions to the problems in our society, my mother is 91, she can no longer do many things on her own without help, my wife and I would go to work and the children must go to school, so tell me do I leave my mother to suffer when there is no one to care for her?...I had at a time employed a maid for her but I found out that she was abusing my mother and I had to send her packing…..so who cares what the culture thinks. (KII 10, 28/08/2018).

Like the Igbo culture, the Yoruba traditional system also accords the elderly with very high veneration such that it makes their care a part of the family's responsibility and anyone differing to the care of their old people particularly the children, is considered as bastard (Omotayo, 2015). It has hitherto been reported that it is culturally unacceptable to take your older person to old people's home as such is seen as a sort of disregard and cultural abuses to the older person. This confirms the position of Togonu-Bickesthet (2014) and Evbuoma (2015). However, as observed by this study, it gradually appears that people (particularly those involved in the care of the elderly) no longer care about the perception of the society on what happens to them and their family. This may largely be as a result of the loss of social cohesion and bond that has been swept away by the supposed globalization that ravaging our culture. The society has become individualized and to a large extent, there is little or no care about what the next-door neighbour thinks about the other person. This ideology is suspected to have influenced the observed reports on the care free attitude of families of users of institutional care facilities. Another reason that could have been responsible for this perceived individualized thought and disregard for cultural disposition may be need driven. The study observed that most of the carefree responses about the cultural dispositions emanated from either the informal caregivers (that is the family members responsible for the care of the older person) or the elderly using this facility. On the part of the care givers, it is an escape from the burden and stress of care while for the elderly it becomes an asylum from abuses and incapacities.

These the elderly who are residents of the institutional care facilities that expressed care free attitude to the cultural disposition of the society on the use of institutional care facilities did so perhaps because the institution is the only available respite meets their immediate needs which the society could not provide for them. Those the elderly who are of this opinion have therefore found satisfaction in these institutional homes. Excerpt of some of their responses include:

> You cannot blame people for using this facility, people have problems and they need to find a way to live. For instance myself, I cannot stay alone in the house and my children have employed maids for me in the past but I cannot cope with them….all my children are living abroad...I have two houses that I built myself but I cannot stay there…I don't know what you expect me to do if I don't come here. (FGD 05 29/07/2018).

The usage of the institutions for some of these the elderly is need driven. Some, for the purposes of putting up with social reasons such as boredom, abuses among others. Others may be for reasons of functional disabilities or deteriorating health conditions. Another resident commented:

> why should I care about what the society thinks? I have very chronic diabetes that is affecting my functional abilities and if I can receive adequate care and attention here for me to live well, why should I care if the society accepts or rejects this facility. (FGD 07, 04/08/2018)

It became very clear to this study that users of these facilities are in the first instance conditioned to be resident there as a result of either social or health incapacities and have to come to accept the institutional care as a norm. Meanwhile, responses from the elderly who are not residents of institutional care facilities but use the facilities as outpatients share a bias sentiment for their fellow senior citizens. They expressed considerable acceptance of the use of the residential care as the only respite care for those who have significant challenges of coping with old age. Apparently, old age comes with significant challenges and the resilience of each individual to cope with the challenges differs. Those elderly who are so unlucky to have chronic health challenges at old age may have no other option than to accept the use of these facilities. This position corroborates Levinson (2008) that posited that the elderly need institutional care as a result of degeneration of health, disability, frailty and incapacity for self-care among others. Some of the elderly commented:

> Our society is gradually accepting the use of institutional care facilities for the elderly because of the conditions old people face. I have a friend who has serious health challenges and he is bedridden.... even his children got tired of packing his excretes before they eventually found a home to keep him...thank God for that home he has now gotten considerable improvement and his children are happy (FGD 06, 02/08/2018).

> Anyone who says old peoples' home is not good is living in the past. Yes! It is not originally part of our culture but it is a better way of solving problems of old people. In those days when there is no old peoples' home, we don't also have....ehm....white collar jobs. Everyone in the family stays together and solves their problems together. But now it is different..." (FGD 09, 16/08/2018)

> You see! It is easier for those people who are not yet old or those who do not have major challenges at old age to condemn residential care for old people. It is just like saying we don't want to be admitted in the hospital when we are sick. People have challenges which is either medical or social and if they get respite in old peoples' home, why should the society condemn it?....you say it is not part of our culture, many of those things we do today, are they part of our culture? (FGD 02, 26/07/2018).

Some of the elderly who differ on the opinion saw it as last resort means of addressing the problems confronting them at old age. It was gathered that no older person would naturally want to use institutional care facility without a substantial reason which is beyond their control. Most of them use the institutional care facility as last resort as they expressed strong preferences to age in their homes. A respondent commented:

> Except when you don't have options, no one will wish to leave his/her home to live elsewhere...there is no place compared to your home. (FGD 10, 28/08/2018).

Even with their strong biases for ageing-in-place, these old people have not condemned the use of institutional care facilities as the importance of the facility has been deeply recognized among them.

Religion has however been hyped in literature (e.g. Chater& Tsai, 2008; Pocinlo, Belo, Antunes, and Rodrigues, 2016) to have a significant influence on the use of institutional care facilities. The argument is that religion assigns meanings to life for the elderly as it reinforces their hopes in life and renews dimensions to surmount intrinsic challenges in the ageing process.

While considering the religious perceptions to the use of institutional care, it was gathered that 96% percent of the institutional care facilities are owned and run by the Christian religious faithful and most of the residents are predominantly Christians. A care provider noted:

> This is a Christian home! The Christian religion clearly supports anything that is good and has not restriction as long as the rules of the scriptures are kept. (IDI 02, 26/07/2018)

The study gathered that the use institutional care facility is more pronounced among the Christians faith. Enquiries about this phenomenon revealed the faith has no particular resentment for the use of such facilities and Churches have encouraged their members who have need for the use of such facilities to use them. Some of these costs of cares are being paid by their churches. A participant stated:

> My religion supports the use of this facility. As a matter of fact, it is my church that brought me here as a result of my chronic health status (FGD 05, 29/07/2018)

Many of the homes have been indoctrinated with Christian activities and they have daily routine schedules for their activities majorly because Christians own these homes. Representatives of churches and parishes are usually allowed to fellowship in the home and some of the homes convey residents to particular churches on Sundays. These homes were found to have provided a spiritual solace for the elderly at least for those who are Christians, at any rate residents in most of these Christian homes are usually Christians. Of significance note, this finding negates the positions of Vitorino and Vianna (2012) that posited that the elderly in institutional care facilities find adaptation more difficult as a result of less access to religious activities and spirituality. Perhaps, the case may be different in a home with multi-religious residents as it may be a little bit difficult for the homes to have a uniform religious programme designed for all residents and such may leave residents his faith. Apparently, Nigeria is more religious conscious and proper attention is been paid to the faith of the residents. A care provider commented:

> We are conscious of the religious duties of the residents. At this stage in life, they have nothing more to crave for in life than to be closer to their Lord, so we pay dutiful attention to their spiritual life (IDI 01, 26/07/2018).

It is sufficient to infer that homogenous religious facility provides more succour that is religious to residents and those who have deficiencies in their religious lives have them

remediated through the routine activities in the homes. However, the case may be different in heterogeneous homes.

Of all the institutional care facilities in the southwest Nigeria, only 5% has a Muslim resident and these Muslims represents less than 12% of the population in the home. This does not imply that the Islamic faith is against the institutional residence for the elderly, but there is obviously lack of provision for Muslims faithful in these institutional care facilities. As noted earlier, most of these homes are built by Christians and they have no obvious intentions to provide residence for Muslims as such provisions are not made.

Residents of the institutional care facilities expressed satisfactory comments and have come to accept the use of the facility as a necessity to cater for their health and social need. Many of the residents have come to accept the facilities as their home and adjusted appropriately to the pattern of care in those facilities. A good number of the residents appear comfortable in most of the homes and seem satisfied within. A respondent commented:

> Since I came here my life has been better and I have been comfortable. While I was at home my blood pressure rises regularly but I thank there has been improvements (FGD 08, 12/08/2018).

Although it is beyond the scope of this work to measure the life satisfaction and quality of life of the respondent but cursory observation of the respondents revealed there is a justifiable level of acceptability. This observation may be on the surface level anyway and may not truly represent the real picture. The older person in these facilities may have less or no option than to accept the use of the facilities. The study gathered that most of the residents of the institutional care facilities in the southwest Nigeria use the facility for either health related or social reasons. It was also gathered that most of them do not have any viable alternative to the use of this facilities hence, they may have no option that to make adequate adjustment to the use of the facilities and express positive acceptance towards it. The study further observed from the focus group discussions that residents who have spent longer period (relatively above nine months) in the homes show absolute acceptability with no resentments whatsoever than those who have spent lesser period. It is sufficed to conclude that the longer an older person spends in the residential care facility the more s/he accepts and adjust to it. One of the respondents commented:

> This place has become my home. At first, I did not like it here but I latter find it interesting here and everyone I live with are wonderful, we see ourselves as one and we share experience (FGD 09, 16/08/2018).

This finding corresponds with that of Bessa, Silva, Borges, Moraes, and Freitas, (2012) which posited that the older person find adjustment difficult at the beginning of institutionalization because of the acute changes in their daily lives which is characterized with new routine that is different with their initial homes. But as they begin to spend more time in the institutions, adaptation begins to take place, hence their choice of acceptance of the facility.

Key informant interviews conducted among the caregivers further revealed that most of those who use institutional care facilities have come to accept the usage as a necessity for the elderly in need. This corroborates the position of WHO (2016) that posited that institutional care facility is a necessity which the elderly have come to accept because it helps them to remediate the deficiencies of acute health service. For the care givers, the facilities help them reduces the huge financial burden of frequent hospital visit and a sure escape from stress of care for their older person. A caregiver noted:

> On our own, it was difficult for us to take care of mama. She had been battling with stroke for quite a while and this has really affected all of us…I mean her children…since we found that residence for her, she has shown lots of improvement and we are happy about that...so for me it is a very welcome development (KII 02, 23/07/2018).

It is instructive to note that the perceived level of acceptability of institutional care facilities in southwestern Nigeria is on the high side. This is justifiable by the increase in the provision of the facilities as observed by the study. It follows a simple logic that if the provision of the facility is not significantly acceptable, there may not be continued establishments of more institutional care facilities. Although, there are dissenting opinions that prefer day-care and home-care services to institutional care, but it was observed that the day-care service may be inappropriate for the elderly whose need for such care is based on acute health challenges. Conversely, the home-care services may be too expensive for the caregivers to afford and the appropriateness of care may not be available. However, the day-care model may be quite acceptable for the elderly who use institutional care exclusively for social reasons having controlled for health-related factors. Meanwhile, the extent and veracity of this fact may be subjected to further research.

The perceived high level of acceptability observed by this research confirms the proposition of Omotayo (2009) that posited that old peoples' home is gradually becoming a norm in Nigeria. The premise of his argument was based on the cultural changes and globalization observed in our contemporary society and likened the acceptability of institutional care facilities for the elderly to that of the crèche, which was hitherto alien to our culture but has inadvertently become a norm in our society today.

Research Question Two: What is the trend and motive for increased establishment of institutional care facilities in southwestern Nigeria?

The study found that prior to the year 2007, there was evidently only one institutional care facility in southwestern Nigeria and that facility was established and managed by the Lagos State Government. Subsequently, there was an observed exponential increase in the establishment of residential care facilities, day care centres for the elderly and nursing care agencies for the elderly in southwestern Nigeria. The study investigated therefore, the trend of these establishments and the motive of establishing them. The study found that most of the care facilities established within the last 11 years were privately owned, only one facility was co-established by the public through private-public partnership. It evidently shows that, the growing interest of the establishment of care facilities for the elderly lies majorly with the private sectors.

Further, most of these facilities have been established strategically at the urbanized regions or state capitals specifically where there are population explosions, for example, all the care facilities in Oyo state are situated at Ibadan and at the more specific urban region. Other care facilities are also established at the mainstream of Lagos. Specifically, 50% of the care facilities established in the last 11 years in southwestern Nigeria were situated in Lagos. This justifies the position that most of the care facilities were established at the urban region where population is grown. Further, the establishment of these facilities can be attributed to the increase in industrialization and dual earner syndrome, which is significantly common in the urban area. Apparently, every member of the family seems to be going for work and therefore leaves no one behind to take care of the older person who may become vulnerable due to incapacity to do self-care and boredom. This finding corroborates the position of Omotayo, (2009) that dual earner syndrome may pressurize the society to accept the provision of institutional care facilities in the future, apparently, the future is here. On the contrary to the position of Evbouma (2012), that community-based care and day-care centres were more prevalent compared to institutional care, the study evidently found out that institutional care facilities are springing up more in last one decade. In essence, there has not been any community-based care facility established so far. Meanwhile, there are evidences that few day-care facilities have been established and more home care agencies are springing up.

Figure 4.2.1 shows the trend of increase in the establishments of institutional care facilities for the elderly in south west Nigeria. It revealed the exponential increase in the establishment of the care facilities within the period of about eleven years. This evidently informs the growing interest in the provision of care for the teeming population of the elderly. The increase noticeably becomes significant from the year 2011 and since then has continued to grow.

The study further investigated the motive of establishment and found that the care facilities were established purposely to render services found unavailable in the social and health care industry. This motive may be for the purpose of business and service provision on one hand and addressing the challenges arising from the neglect of care and management of the elderly whose population is increasing significantly. Although the study gathered among the facility care providers that some of their facility activities started as a form of non-governmental organizations, which is mobilizing the elderly to live a sustainable live. Some of them started as a public awareness group for the elderly and retirees towards sensitizing them to remain active after retirement. A few others started with nursing care agencies that deliver home services for the elderly. However, the pressure from the increasing number of incapacities of the elderly, and the demand for institutional care, has influenced many of them to making decision of establishing institutional care facilities for the elderly. A caregiver during an interview commented:

> We started this home as a voluntary nursing care for the elderly, we use to mobilized them for health and physical activities….until one day when somebody just call us, my partner and I, that eehm…you people care for the elderly now, I have brought my mother from Asaba and I want to handover her care to you (IDI 08, 12/08/2018).

Some of these facilities care providers found this service provision missing and decided to explore the unavailability of the services for business advantage. Others have lived overseas and placed value on elderly care services as a prosperous business. Having established therefore that most of these care facilities established in the last decade are privately owned, it is sufficient to infer and summarize that the motive of the establishment are evidently for the purpose of service provision for the increasing number of the elderly who are desirous of such residential services and for economic and commercial purpose, hence it was another business hub opportunity for stakeholders and professionals in the social and medical management of the elderly.

Although, some of these care facilities claimed to be voluntary and non-profit making organizations that provide care for the elderly, evidences available to this study revealed that all of these care facilities levy charges for the care they provide.

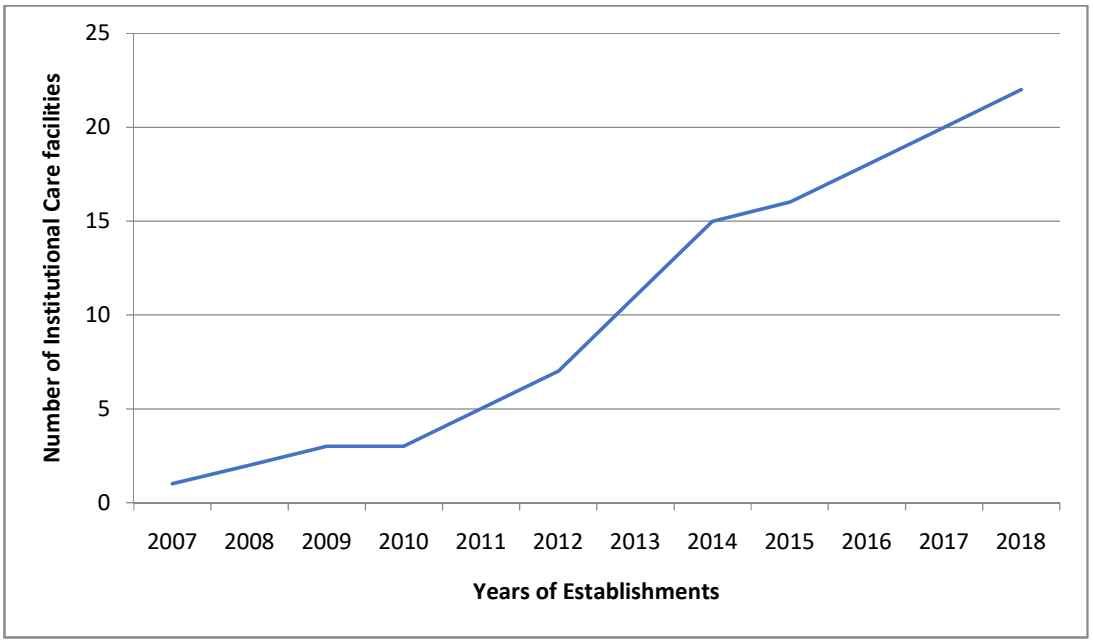


Figure 4.2.1: Distribution showing the trend of establishments of institutional care facilities for the elderly.

Research Question Three: How do the social and demographic characteristics predict the utilization of institutional care facilities in southwestern Nigeria?

Leveraging on Anderson's framework, the study identified the demographic characteristics influencing the utilization of institutional care facilities as age; gender; marital status; social factors (family size and structure, Childlessness, education, loneliness and isolation, abuses, and depression); and health factors (functional disability, cognitive disability and deteriorating health condition). Apparently, the study measured these characteristics on the current residents of the institutional care facilities in southwestern Nigeria.

Table 4.3.1: How social, demographic and health factors predict the use of institutional care facilities

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	102.088[a]	.240	.330

Chi-Square (X^2) = 35.4

Significant at P<0.05

The result in table 4.3.1 shows the logistic regression that was carried out to ascertain the effect ofsocial, demographic and health factors as they influence the use of institutional care facilities in southwestern Nigeria. The logistic regression model was statistically significant $X^2(12) = 35$, $P < .005$. The model explained 33.0% (Nagelkerke R^2) of the variance in the use of institutional care facilities and correctly classified 51.0% of class. The result shows that the independent variables (social, demographic and health factors) are determinants of utilization of institutional care facilities

Table 4.3.2 shows the sign of the coefficient of demographic factors (age, gender, marital status) social factors (family size and structure, Childlessness, education, loneliness and isolation, abuses, and depression); and health factors (functional disability, cognitive disability and deteriorating health condition). The result shows that the demographic factors, age (**β**=0.148; p<.05), gender (**β**=1.950; p<.05), and marital status (**β**=0.99; p<.05) were associated with the use of the institutional care facilities. The social factors, family size and structure(**β**=-.006; p>.05) Childlessness(**β**=-.022; p>.05), Education(**β** = .047; p>.05),loneliness and isolation (**β**=.-1.676; p>.05), and income (**β**=-.030; p>.05) were not significant factors influencing the use of institutional care facilities. Meanwhile depression (**β**=.171; p<.05) was found to be significant factors influencing the use of institutional care facilities. All the health factors were found to significantly influence the use of institutional care facilities, as found with functional disability (**β**=.087; p<.05), cognitive disability (**β**=-.053; p<.05)and deteriorating health status (**β**=.110; p<.05).

Table 4.3.2: Relative effects of social, demographic and health factors influencing the use of institutional care facilities.

Variables in the Equation							
		B	S.E.	Wald	Df	Sig.	Exp(B)
Step 1[a]	Age	.148	0.038	15.304	1	.000	1.159
	Gender(1)	1.950	.842	5.356	1	.021	1.006
	Marital status	.099	0.48	4.266	1	.039	.906
	Family size and Structure	.006	.002	.065	1	.799	1.006
	Bareness	022	.036	.358	1	.549	.979
	Education	.047	.035	1.784	1	.182	.954
	Loneliness	-1.676	3.336	.253	1	.615	.187
	Depression	.171	.039	4.347	1	.000	1.201
	Income	.030	.025	1.195	1	.233	.023
	Functional Impairment	.087	.052	1.683	1	.054	.015
	Cognitive Impairment	.053	.026	2.061	1	.040	.780
	Deteriorating health condition	.110	.046	2.420	1	.016	.912
	Constant	-1.898	2.679	.502	1	.479	.150

Significant at P<0.05

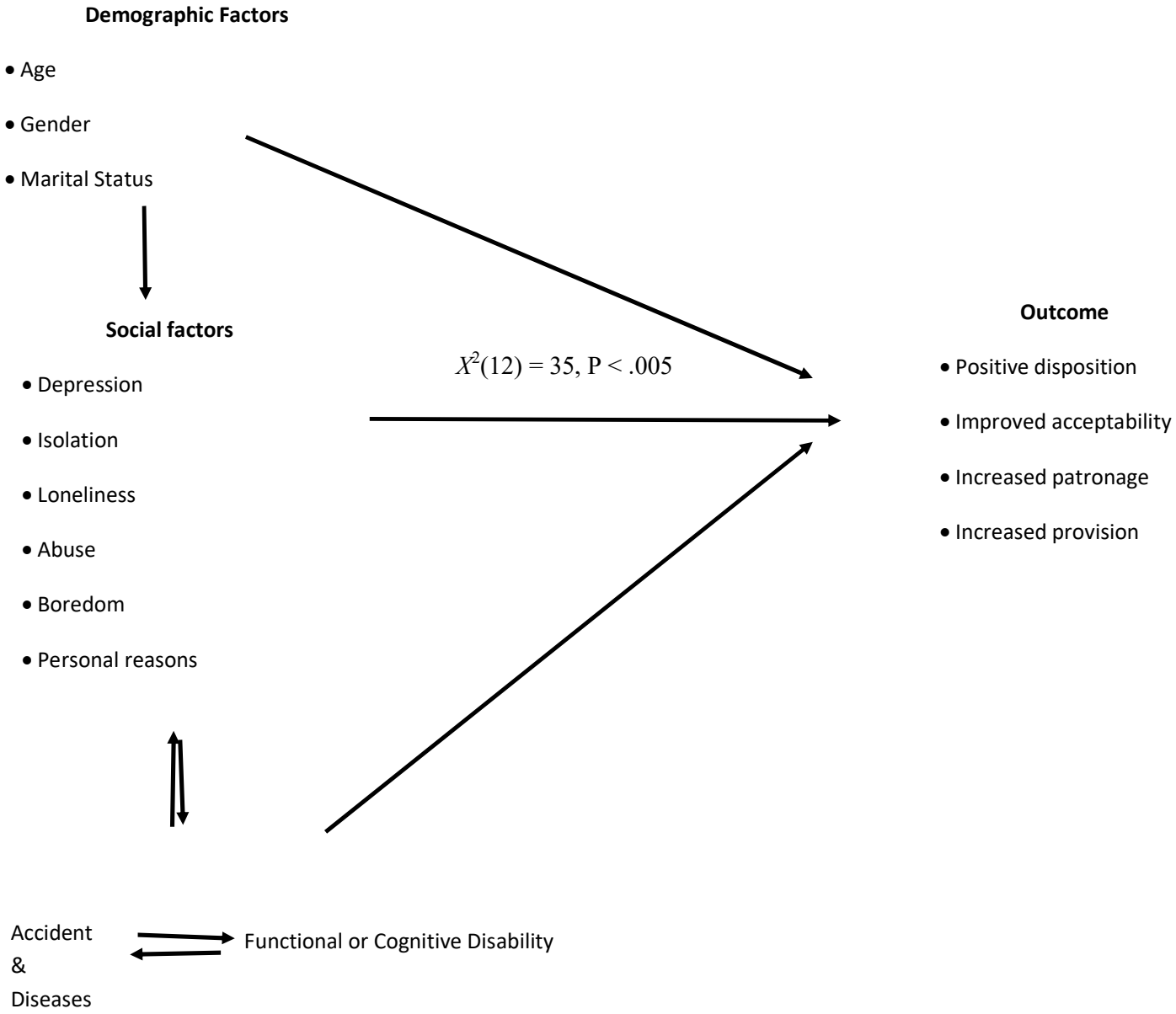


Figure 4.3.1 Relationship between variables and outcome

Age

Age has been identified as a significant determinant of utilization of institutional care facilities. This study specifically found out that the older an individual is, the higher the tendency of utilizing the institutional care facilities. It was revealed that the number of the elderly in institutional care facilities increases as their age bracket increase. Analytically from the study, 7% of the respondents in institutional care facilities surveyed fall within the age bracket of 60-64 years, 13% fall within the age range of 65-69 years, about 23% fall within the age range of 70-74 years, about 26% fall within age range of 75-79 years and about 31% fall within the age bracket of 80 years and above. This finding is consistent with the previous findings in the literature which established that the youngest group of the elderly which are the people within the age range of 60-64 years and 65-69 years have the lowest probability of utilizing the institutional care facilities and the old-old category that is, the elderly that are above the age of 80 years have a very high probability of utilizing care facilities. As argued in literature, (Einio, 2010; Mustard, Anderson, Derksen & Barthlot, 1999) the prevalence of the elderly care increases with age if other factors are controlled. These factors include functional and cognitive impairment among others. In simple terms, only the elderly in the category of young-old (60-69 years) with serious incapacity such as inability to do self-care and activity of daily living would necessarily use institutional care facilities.

Meanwhile, less for the emerging societal changes that may pressure family system to transfer the burden of care for their the elderly with incapacities to institutional care as propounded by family support theory, institutional care facilities would have been predominantly meant for the old-old category (80years & above). However, as it currently stands, the care facilities are still dominated by this category. The inference of this study means that there is a significant relationship between age and institutional facility provisions without the interference of health factors among others.

Gender

The study found that women are more represented in the institutional care facilities than men. 31% were male while 69% were female. This shows a significant difference in gender characteristics of residents of institutional care facilities in southwestern Nigeria. This finding is consistent with findings in literature (Grundy & Jitlal, 2007; Anderson & Kane, 2007; Einio, 2010) that women are more likely than men to use institutional care facilities at old age. This may likely be as a result of the perceived increase in the life expectancy of

women which is higher than men. In other words, if there is possibility for women to live longer than men, then the population of women at old age would be higher than men.

Deductively, it is expected to have higher percentage of women at old age in institutional care facilities than men, if all factors remain the same. Another factor to be considered is the presumption that men have higher mortality rate than women, then it is consequential that there would be more widow population who are likely to become more vulnerable and suffer more incapacities as a result of bereavements among others. This position may require further study for proper validity.

Marital status

The study found out that all the residents of institutional care facilities fall into three categories of marital status. About 19% of the residents were separated; about 23% were divorced while about 58% were widows. None of the residents in the facilities surveyed were married and this informed that they are without the care and affection of a spouse. This may particularly be a pointer to having a higher probability of utilising institutional care facilities. Perhaps, if an older person is married, the tendency of using institutional care facilities may be lower or even avoidable. Where functional and cognitive impairment threatens the spouse maybe a supportive fixation to surmount the challenges and provide necessary care. This position is not totally different from that of Aikoje, (2013) and Omotayo, (2015) that the elderly living with their spouses have higher life satisfaction index than those who are widowed, divorced or separated. As evidently shown by this study, marital status is a significant order among the characteristics influencing the utilization of institutional care facilities in southwestern Nigeria.

Family size and structure

This study measures the significance of family sizes and structures because it affects the propensity of utilising institutional care facilities. The study categorized the structure of family basically to nuclear and extended and the size of family to large, medium and small. The sizes and structures of families of residents of institutional care facilities in southwestern Nigeria surveyed were with a view to determining whether there is a relationship between the structure and sizes of the resident's families and the use of institutional care facilities. The study found that about 22% of the respondents have a relatively large family; about 35% has medium sized family, while about 43% has small family sizes. Similarly, 61% of the respondents claim to have a nuclear family structure while 39% is relatively from extended

family structure. It is evident that residents with nuclear family structure are predominantly higher in the institutional care facilities than those with extended family structure. However, there are no enough empirical evidences to conclude that residents with nuclear family structure are more likely to use the institutional care facilities. It is becoming apparent that extended family structure is weaning off and families are becoming individualized, yet that does not justifies that such syndrome could determine the usage of institutional care facilities.

The study found significant presence of residents with extended family in institutional care facilities and this is a pointer to the fact that the structure of the family may not necessarily determine the use of institutional care facilities. Contrary to the assumption that it is the responsibility of the family system through the extended family structure to take care of the elderly, the reality in today's world is that every member of the family has been preoccupied and do not play the supposed role particularly for the elderly with huge expectation of care. In other words, extended family structure in today's society does not independently guaranteed a secured care for the elderly largely due to a changing social norms and dual earner syndrome.

In the same vein, large family size cannot also assure the elderly of proper care. Evidently, the study observed the presence of residents with large family size in the institutional care facilities, although with relatively small percentage, yet it is not sufficient to empirically infer that the size has an independent effect. Insight into focus group discussion revealed that the size of family may not necessarily reduce the probability of use of institutional care facilities. Many of the residents with large family size lamented the unavailability of their family members to see to their care due to the pressuring societal demands for economic survival. A respondent commented:

> I have six children and all of them practically work with government establishments. Their children will go to school and I cannot stop them from pursuing their lives…I was at a time putting up with some of them and they were transferring me from one place to another (FGD 05, 29/07/2018).

This finding that size and structure of family do not necessarily influence the use of institutional care facilities is inconsistent with the position of Bachand and Caron (2001) that the size of family will, in a way determine propensity to use institutional care facilities.

Childlessness

Contrary to report and literature (e.g. Grundy &Jitlal, 2007) that lack of children is a significant factor to consider as a determinant of utilising institutional care facilities, this study found that only 14% of the resident in institutional care facilities in southwestern Nigeria were childless either without any child or have lost their child(ren). By implication, 86% of the residents have children who are directly or indirectly responsible for the expenditures of their care. This varying result may be as a result of drastic change in socio-cultural values. It seems not to be important whether or not an older person has a child to determine his/her use of institutional care facilities. Apparently, those with children are the ones that evidently dominated the institutional care facilities as surveyed by the study.

Varying reports in literature have hitherto posited that childlessness and gender of child (ren) may influence the use of institutional care facilities as having daughters was reported to have significant relationship with low use of institutional care facilities. This study however found this position inconsistent and insignificant.

Income

Evidence in studies from foreign countries (e.g. Mustard et al., 1999; Hoancock et al., 2002; Einio, 2010) reported that there is a significant relationship between income of the elderly and usage of institutional care facilities. Meanwhile, this study does not found any relationship between the two variables. This is because all the residents of the institutional care facilities surveyed do not have any concrete source of income but depend on the care and support from children and family members. It is therefore difficult to estimate the average income for such older person who is largely dependent on care from family members. Some of the elderly depend on support from religious and charity organizations for their care. It is therefore difficult to measure the relationship between income and the use of institutional care as most of the elderly do not have a significant income.

Education

The level of education of an older person does not have any significant effect on the use of institutional care facilities. This study found out that only about 18% of the residents were illiterate, about 22% had primary level of education; about 43% had secondary level of education while about 17% had a form of tertiary education or the other. Contrary to the position of Togonu-Bickersteth (1999), that the vast majority of the elderly in Nigeria may

be indisposed to the use of institutional care facilities due to low level of education, this study found this position to be inconsistent. About 60% of the elderly sampled have secondary level of education and above and this significantly shows that the level of education of most of these residents is higher. It is not enough therefore to conclude without considering other factors that level of education may or otherwise pressure the use of institutional care as it may be least insignificant factor to consider while making the choice of institutional care facilities usage against other factors such as functional and cognitive impairment, depression and other social challenges.

Social factors

This study identifies the social factors that may influence the use of institutional care facilities for the elderly to be numerous. These factors range from depression, personal safety, isolation, loneliness or boredom, abuses to personal circumstances. The study found that, although, there are possibilities of utilising institutional care facilities for social reasons, the percentage of residents in this category is evidently less than 25% and this may mean therefore that the elderly with social challenges prefer to use day-care and outpatient facilities. This study is consistent with the position of OECD (2005), and Murphy et al., (2006). Social reasons though influence the activities of the elderly; it is not substantive enough to influence the use of institutional care facilities.

Interactions with the residents revealed that loneliness and boredom is a strong factor among the social reasons that may likely influence the use of institutional care facilities for the elderly. A respondent commented

> Everybody in the house will go to work and leave me alone at home doing nothing, three of my grandchildren stay with me but they usually pursue their personal lives without considering my care. Their parent lives abroad and I am helpless to stay with them. (FGD 09, 16/08/2018).

Another respondent noted

> I live with my only son and his wife takes good care of me until he was transferred to Port-Harcourt, I was meant to live with the maid who eventually becomes uncontrollable for me and it is a big house, how can I live alone (FGD 06, 02/08/2018).

For these residents, the institutional care facility is an escape from boredom, isolation and loneliness among other social reasons that may influence the use of institutional care facilities.

Health

Health related factors have been found by this study to have significant influence on the utilisation of institutional care facilities by the elderly. The study found that more than 75% of the residents in the institutional care facilities have one or two health issues. Although as a result of old age, the elderly are susceptible to precarious health challenges, yet without any significant incapacity, there may not be need for institutional care service. Beyond this, the study found out that out of all the residents in the care facilities sampled, 76% was unable to do self-care and this implies that they require help to take their bath, wear their clothes, use toilets and so on. This may not necessarily mean that they suffer significant health challenges but frailty and general body weakness that accompany old age may be responsible for this. In any case, decline in physical agility and wellbeing is a component of health challenges. Similarly, the study gathered that 77% of the residents have functional impairment and about 79% has cognitive impairment. This is consistent with the position in literature (e.g Baneszak-Holl et al., 2004; Einio, 2010) that functional and cognitive impairment are the first line determinants of utilisation of institutional care facilities. This bothers on the inability of the activities of daily living and instrumental activities of daily living.

Other specific health challenges may also be accountable for the use of these facilities but it was beyond the scope of this study to disaggregate the specific influence of each health condition and disease on use of institutional care facilities for the elderly. It is also important to note that inability to do self-care occasioned by precarious health challenges take precedence over social factors as determinant influencing the use of institutional care facilities.

Research Question Four: What is the capacity of the existing institutional care facilities for the elderly?

The institutional capacity of care facilities in southwestern Nigeria was measured with the assessment of the physical and structural designs of the facilities ranging from purpose of building; types and number of rooms; types and number of bathrooms and toilets; call bell facility to communal facilities, services available at the facilities such as medical, social and psychological services and the staff resources available as at the time of the study.

The facilities were assessed based on structural design and purpose of building the structure. The study found out that about 45% of the facilities were purposely built for institutional care and 35% out of these purposely-built facilities are privately owned (Fig. 4.4.1). This implies that the remaining 55% of the facilities were designed for purposes other than institutional care and this is still observed in the present status of the facilities. Meanwhile, the use of these facilities may be a little bit challenging, as they have not been structurally designed to accommodate frail and weak people such as the elderly.

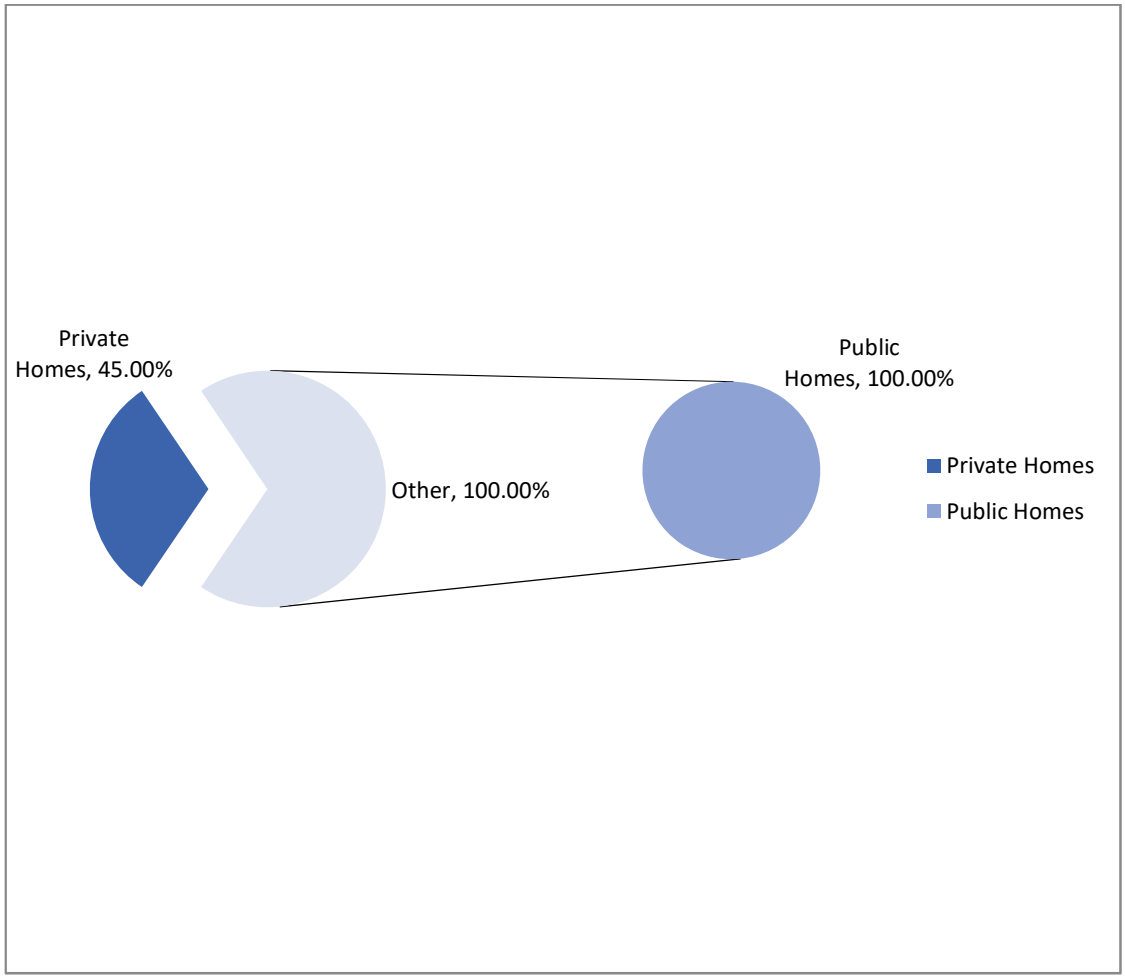


Fig. 4.4.1 Distribution of Institutional care facilities based on purpose of building

The expectations of the structural design of buildings to take care of the needs of these people should be wheelchair complaints, devoid of stairs, have grab rails fixed within among others. Paradoxically, majority of these institutional care facilities that were built for other purposes have not been redesigned to suit purposes that will ease life of the residents and their care providers. This has continued to pose great challenges for the residents and their care providers particularly as it affects their free movement from within and around the care facilities. In-depth interview with the care providers reveals that most of the facilities were rented and they do not have permission of the owners to make structural adjustment to the buildings to suit their purpose of use, for instance, a respondent commented:

> We are constrained to manage this building because it is a rented apartment. It stressed us more particularly when we have to lead the resident through the stairs each time they want to move around (IDI 04, 25/07/2018).

This challenge has hampered and incapacitated the caregivers as it pulls huge stress on the care providers and the residents. This finding corroborates the position of Parker et.al., (2004) that residents may rely on the structural plan and design of the facility settings to reinforce their diminished mobility. Although, some of the facilities that were built for purposes other than institutional care have been slightly adjusted to accommodate a few conveniences.

Types of rooms

Figure 4.4.2 shows the percentages of rooms in the institutional care facilities in southwestern Nigeria disaggregated by the type of ownership, its private and public homes. It reveals that 21.5% of rooms in the privately-owned facilities are single rooms while 78.5% are double rooms. It further shows that most of the privately-owned institutional care facility do not have large wards that occupy three people and above. Meanwhile, in the public owned, that is, facilities built by government, 40% of the rooms are single rooms, 40% are double rooms and 20% are wards (large rooms that have three people and above). This implies that privately owned institutional care provide residence with more private care facilities and give them access to separate rooms and other fit-in facilities. Although, this cannot be independently accessed in terms of care provisions for the elderly as these provisions may imply huge cost of care in private institutional care facilities.

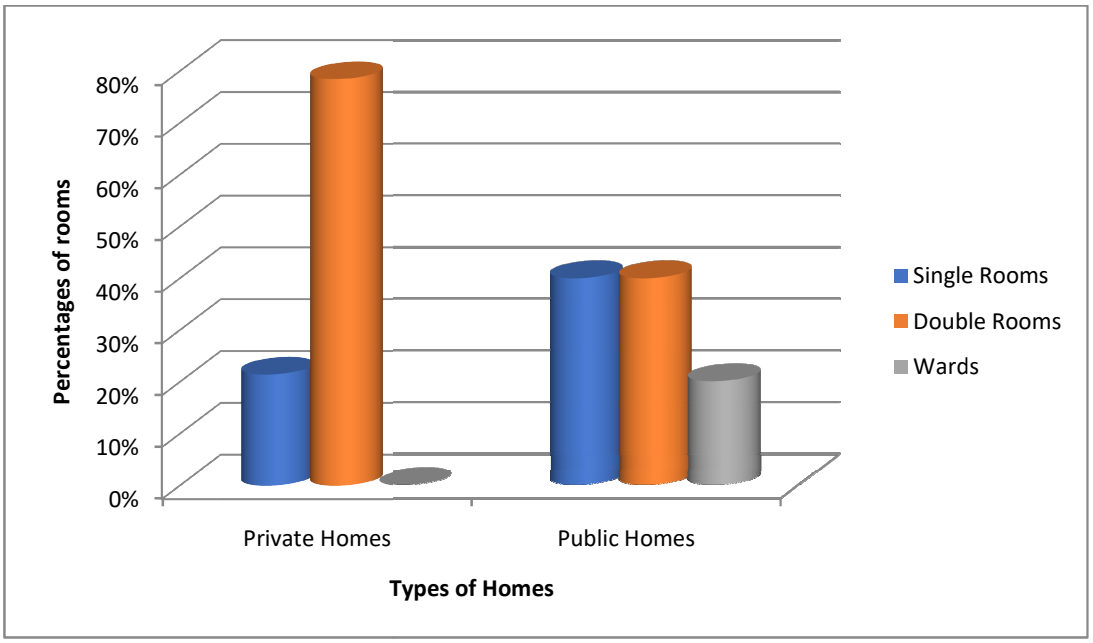


Fig. 4.4.2 Distribution of types of rooms in the care facilities

However, if the costs of residence in the care facilities are controlled, it is enough to infer that private homes provide more comfortable care in terms of capacity of resident per room compare to public homes. Meanwhile, the ratio of private homes facility in southwestern Nigeria to public homes is 1: 10 (Fig. 4.4.3).

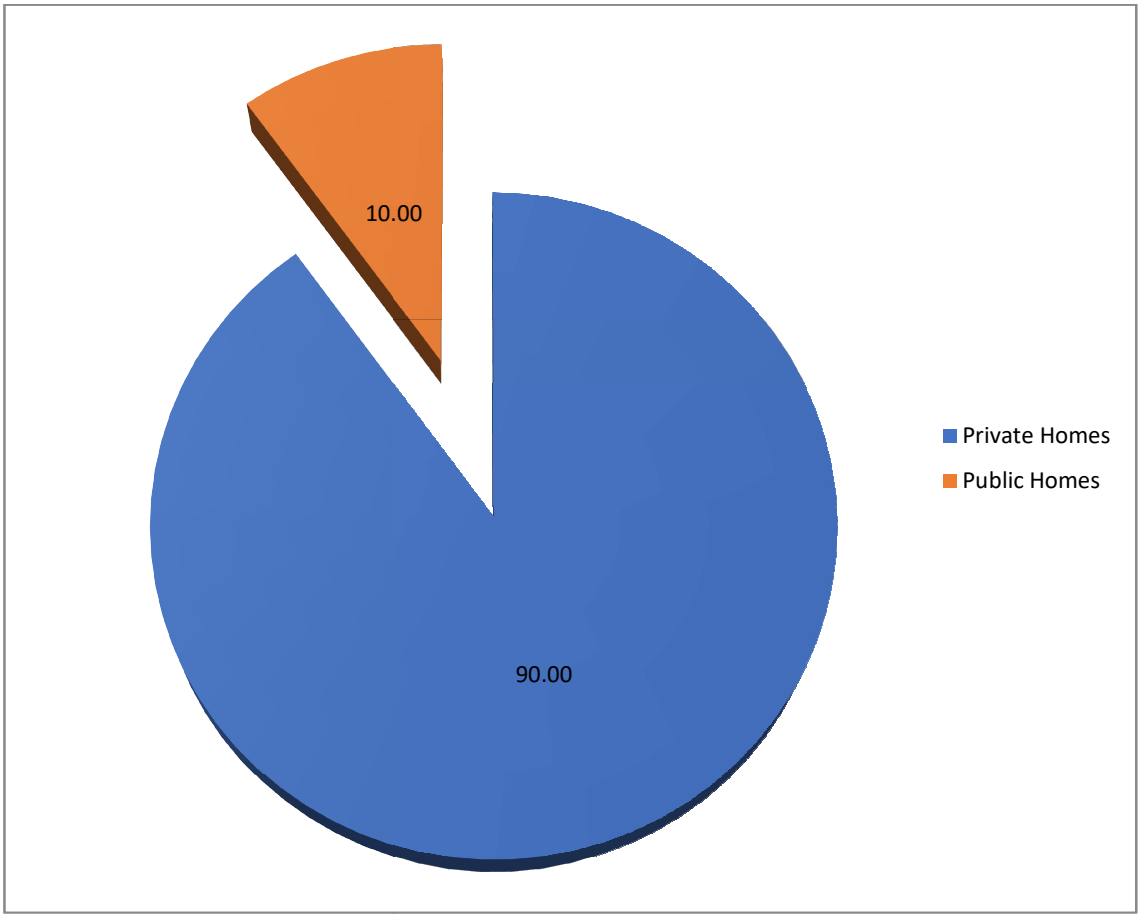


Fig. 4.4.3 Distribution of types of facilities based on ownership

Table 4.4.1 shows the distribution of types of activity rooms in each facilities ranging from dining room, sitting room, reception room and others such as garden. It reveals that about 40% of the facilities have separate sitting room, 45 % has separate dining room, 35% has their sitting and dining room combined together, 25% has their sitting room and reception combined together, 55% has separate reception room, while 35% has separate reception room and only 25% has garden. None of this facility has child friendly area and specific visiting room other than the reception.

Table 4.4.1 Distribution of Room facilities provided in the Institutional care facilities

Room Category	Frequency	Percentages
Separate Sitting Room	8	40.0
Separate Dining Room	9	45.0
Combined Sitting and Dining Room	7	35.0
Combined Sitting and Reception Room	5	25.0
Separate Reception Room	11	55.0
Garden	5	25.0

Table 4.4.2 describes the average minimum and maximum number of beds in the facility for both public and private homes. The private facilities have minimum number of 10 beds and maximum number of 25 beds with the mean value of 36.1 and the total number of bed facilities is 649. While for the public homes, the minimum number of beds is 8 and the maximum number is 19 with the mean value of 13.5 and the total number of beds is 27. This instructively shows that the private institutional care facility in southwestern Nigeria has more capacities than the public care facilities.

Table 4.4.2 Distribution of Number of Beds in the Institutional care facilities

Type of Homes	Frequency	Min	Max	Mean	Total
Private Homes	18	10	25	36.1	649
Public Homes	02	08	19	13.5	27

This is not surprising however, given the ratio of public institutional care facilities to private institutional care facilities as shown in figure 4.3.3. Succinctly, the total number of bed spaces surveyed is 676 distributed among the 20 care facilities in southwestern Nigeria. This evidently shows the moderate capacity of the care facilities to provide residential care for the elderly in southwestern Nigeria. Meanwhile the total number of respondents surveyed for this study was 264 while the bed space capacity for residents in the care facilities was 676. This therefore justifies the moderate capacity of the care facilities in southwestern Nigeria.

Table 4.4.3 revealed the ratio bathroom facilities that are available within the institutions. It specifically shows the ratio of facility to residents in terms of accessibility to bathroom and water closet. For single rooms, the ratio of facility to residents in terms of accessibility to bathroom and water closet is ratio 1:8.3, that is, single rooms with en-suite facilities to the number of residents is approximately 8 residents to one room and these are mostly available at the private home. The table further shows the availability of fixed grab rails in the facilities and these reveals the ratio of fixed grab rails to residents as 1:22.1. Further, access to separate water closet system within the facilities by residents gives a ratio of 1:10.3.

Table 4.4.3 Distribution of Ratio of Bathroom facilities to residents

Type	Facility Ratio	Residents Ratio
En-suite rooms	1	8.3
Separate Water Closet	1	10.3
Fixed grab rail	1	22.1

In the same vein, figure 4.4.4 shows the distribution of call-bell facilities within the residential institutions in southwest Nigeria. This table reveals that only 45% of the care facilities have call-bells within their institutions and these call-bells are only available at the resident's room. The call bells are evidently missing in the bathrooms, toilets, corridors and other parts of the buildings.

Fig. 4.4.4 Distribution of call-bell facilities in the Institutional care facilities Services

The services available in the institutional care facilities were assessed and classified as: physiotherapy, occupational, speech therapy, social work, psychology, chiropody, dental, optical, hairdressing among others (see Fig. 4.4.5). The study found that about 40% of the institutional care facilities have physiotherapy services, about 65% has social work services, about 65% has hairdressing services and other services classified as general care services have about were also available in 72% of the residents. Other services such as occupational therapy, speech therapy, dental and optical services among others were usually referred to nearby specialist. Some of the care facility providers invite consultants from affiliated institutions or medical centres to provide these services.

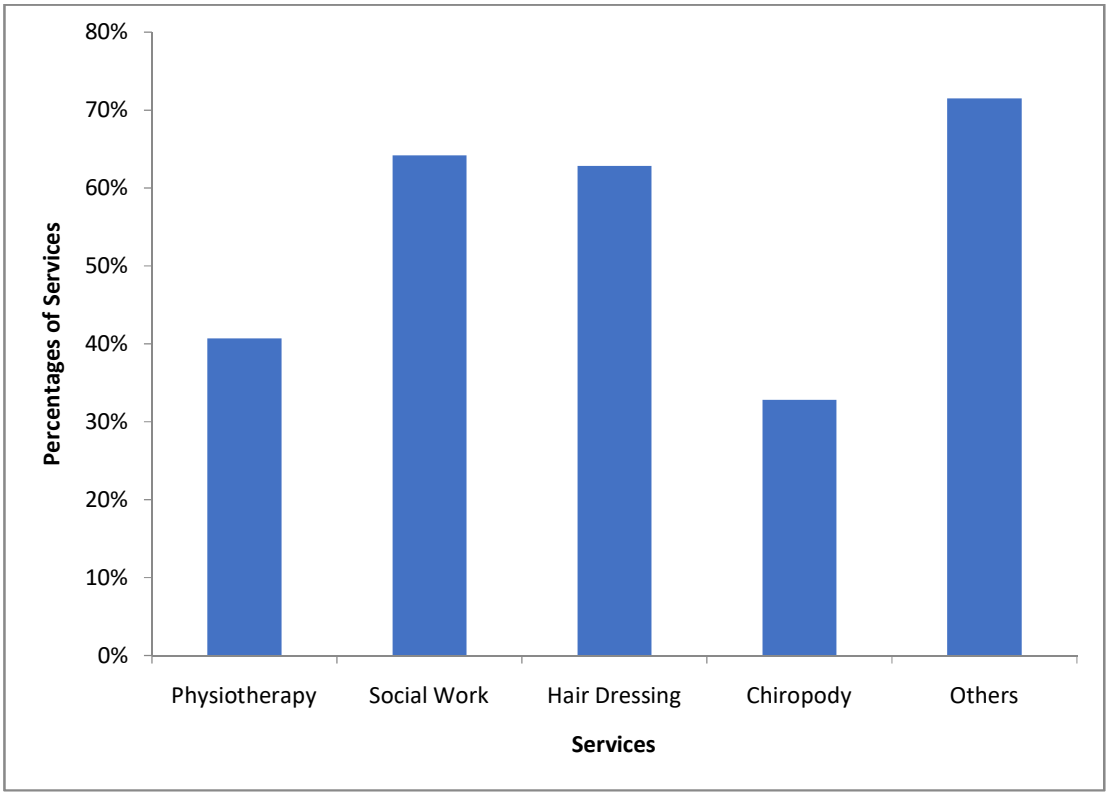


Fig. 4.4.5 Distribution of Services at the institutional care facilities

Table 4.4.4 also reveals the communal services available in the institutional care facilities. The services identified were traditional games, art activities, organized dancing, cultural activities, gardening, complementary therapy such as massage and physical exercise programmes. All the care facilities have one traditional games or the other. Only 5% has art activities and organized dancing. About 25% has cultural activities, only 15% has gardening and complementary therapies while 60% has light physical exercise programme for the residents.

Table 4.4.4 Distribution of communal services available at the care facilities

Services	% in Private Homes	% in Public Homes	Total
Traditional Games	90	10	100
Art activities	05	-	05
Organised Dancing	05	-	05
Cultural activities	60	05	65
Gardening	15	-	15
Complimentary therapy	15	-	15
Physical Exercise	55	05	60

Similarly, table 4.4.5 shows the complimentary communal facilities available in the institutional care facilities across southwest Nigeria. These facilities include: games, musical instruments, Television and DVD, Newspaper resources, Library and book lending, and public telephone. All these institutional care facilities have television and DVD facilities, about 40% hasnewspaper resources, only 10% has library and book lending facility, all the facilities have game facilities with wide range varieties, about 60% has public telephone while only 10% has musical facilities.

Table 4.4.5 Distribution of complimentary communal facilities

Facilities	% in Private Homes	% in Public Homes	Total %
Television/DVD	90	10	100
Newspaper resources	40	05	45
Library/Book Lending	10	05	15
Games	90	10	100
Musical Instruments	10	-	10
Public Telephone	60	20	80

Further, table 4.4.6 indicated the ratio of staff to residents in the care facilities. In the privately-owned facilities, the ratio is 1 staff to approximately 4 residents while in the public facilities, the ratio is 1 staff to approximately 5 residents. This staff population includes: the care attendants, nurses, social workers, cooks and other domestic workers in the facilities.

Table 4.4.6 Distribution of ratio of staff to residents

Types of Facilities	Staff Ratio	Residents' Ratio
Private Homes	1	4
Public Homes	1	5

Figure 4.4.6 revealed the distribution of the categories of staff available in the residential care facilities for the elderly. The figure shows that about 15% of the entire staff in both private and public facilities has Registered Nurses with the public facilities having the higher number of nurses as staff. 55% of the staff in the facilities are care attendants who basically have the responsibilities of attending to the basic and daily needs of the residents, with 30% of them in the private facilities. About 22% of the staff in the facilities survey are health assistants who primarily have basic health care and first aid training and assist the nurses when needed. More than 13% out of the health assistants are in the private facilities. 14% of the staff are porters or and receptionist as the case maybe, with above 8% of the in the private facilities. About 33% of the staff are cleaners, 15% are cooks, 12% are administrators while 30% fall within other categories such as security, gardeners, hair stylist among others.

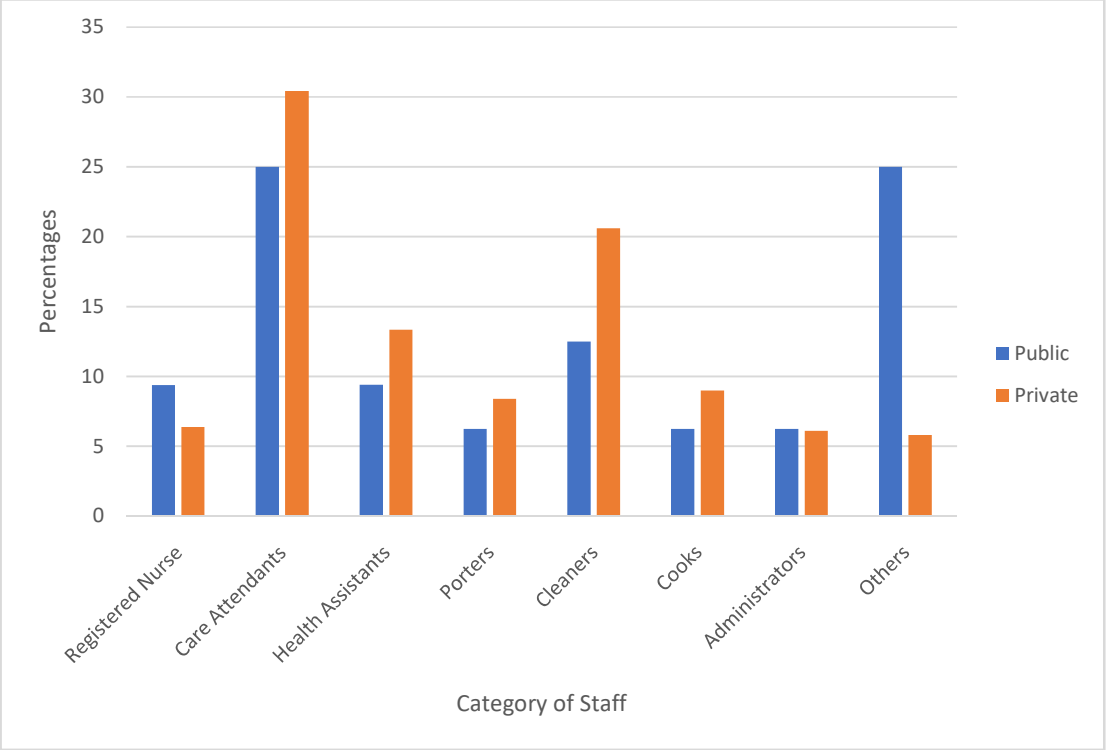


Figure 4.4.6: Distribution of Staff Categories in Institutional care facilities

This figure apparently shows very limited number of nurses available for the care of the elderly particularly among the private residence. Whereas other data available to this study has established that about 75% of the users of the care facilities are those with functional and cognitive disability who may require the attention of qualified nurses periodically. It also implies that the larger percentage of staff in the facilities are the care attendants who are not specifically trained for special skills but handle general chores and obtain instrumental care for the residents. Meanwhile cursory observation at the facilities revealed that though there are fewer professionals who are direct staff of the facilities, yet most of the facilities operate referral systems and collaborative care with hospitals and medical practitioners who render consultancy for patients as and when the need arises.

In conclusion, with the basic assessment of the physical facilities, services and staff resources available at the institutional care facilities in southwest Nigeria at the time of this study, the institutional capacities of the care facilities in southwest Nigeria can be adjudged to be moderately sufficient to cater for residential care of prospective and current residents of the various care facilities.

The implication of this finding for institutional capacity of these facilities may mean that the facilities possessed moderate capacity for care of the elderly and this influenced greatly the pattern of care in the facilities. This finding corroborates the position of Einio, (2010) that capacity of institutional care facilities to provide comfortable residence and pattern of living influences the adjustment and rapid acceptability of the residents to the lifestyle in the institutional care facilities. This bother on the capacity of the facility to provide enough private residence that ensure privacy and choice of activities among others.

Research Question Five: What is the legal provision for institutional care facilities in southwestern Nigeria?

The Federal Republic of Nigeria has no regulation or specific policy guiding the establishment of institutional care facilities in the country. Apart from the social development policy that identifies a national guideline for the care of the elderly, which is rooted in the traditional respect, and high veneration of the elderly, there has not been any concerted effort specifically targeted at institutional care facilities for the elderly. However, the social development policy, which specifies the care of elderly, was designed majorly to strengthen the traditional support system for the elderly such as neighbourhood, family kinship and extended family system on one hand. Conversely, it emphasizes the use of institutional care facilities for the elderly and gives credence to community-based support system for the elderly. Meanwhile, evidences available by this study show that this policy framework has become obsolete as our community system is becoming individualized, traditional system has been eroded, kinship and extended family system are weaning off.

With the evident realization of the failed traditional support system and community-based system, the Federal Government of Nigeria through the Ministry of Women Affairs and Social Development instituted and promoted the establishment of day care facilities and centres for the elderly. Consequently, it issues the guideline for the establishment of day care centres for the elderly, which stipulates the minimum facility requirements for the establishment of the day care centres. The guideline was divided into 8 major categories and specifies the requirements for each of the categories. The categories include: provision of common hall, recreational parks, medical units, reading rooms/library, gymnasium, café/refreshment centre, administrative block and perimeter fencing.

Table 4.5.1 List of Requirements for the establishment of Day care Centers for The elderly

Category	Requirements
Common Hall	This should consist of: • Settees • TV set with satellite facilities • Video machine • Newspaper and magazines • Cable • Restroom attached • Radio with cassette and C.D player
Recreational park	This should consist of: • Ludo games • Draft • Scrabbles • Chess • WHOT cards • "Ayo"/ "Dara"/ "Nchor" • Table tennis • Badminton
Medical Unit	This should consist of: • Consulting room • Observation room • Waiting room • Nurses office • First aid facilities • An ambulance
A reading room/ library	This should include: • Bookshelves • Books on a variety of subjects • Chairs and Tables • Journals, magazines and Newspapers.
A gymnasium	This should consist of: • Various machines for exercise
Refreshment/ café Center	This should consist of: • Tea cups and spoons • Kettles • Beverages, tea and biscuits • Honey • Snack stand • Chairs • Tables • Trays • Plate • Refrigerators • Tea kettles • Tea flask • Deep freezers
Administrative block	This should consist of: • Facility manager's office • Administrative officer's office • Account office • Secretary's office • An office space for supporting staffs (Cleaners)
Perimeter fence with gate house	Security men to wash over the premises

(Source: Federal Ministry of Women affairs and Social Development)

It is instructive to note that the guidelines are specific for outpatients' care services. Very recently however, the Federal Government of Nigeria promulgated an act titled; "the National Senior Citizen Centre Act 2017" and was signed into law in January 2018 by President Muhammadu Buhari. The centre has a mandate of providing support, in all ramifications, for senior citizens in Nigeria. Although, the operational definition of senior citizens in the act include an older person not lesser than the age of 60 years, the act that establishes this centre is silent about whether the centre could provide institutional support for the elderly.

Salient legal issues of requirement for institutional care provisions in Nigeria is found missing in all policy document of the Federal Republic of Nigeria. Issues such as: registration requirement, licensures, admission requirements, processes and quality of care specifications, facility design requirements among many others have not been considered for proper legal documentation. This study however, observed a wide variation across the established care facilities and discretionary measure adopted by care provider since there were no specified guidelines. One of the respondents among the caregivers lamented:

> We do not have specific guideline of operation, as a matter of fact, the only thing we were required by the ministry of women affairs was to pay registration fee and obtain cooperate affairs commission certificate. There was no guideline of operation or policy document to refer to… (IDI 06, 02/08/2018)

Important measures such as: admission, standard of care, contract of care, welfare and wellbeing of residents, personal possession, discharge planning and regulations, staffing, accommodation and facilities, structure designs, hygiene, sanitary facilities, nutrition, records, medical care, death and dying or end of life care, inspections, channel of complaints among others. The facility care providers continue to adopt a trial and error in their operations since there were no specific policy guidelines to direct their operations. This evidently shows that the institutional care facility provision in Nigeria is lacking a legal framework of practice and standard requirement for operations.

Research Question Six: What is the cost per unit of care for the elderly in the existing institutional care facilities in southwestern Nigeria?

The cost of care in the institutional care facilities varies from one facility to the other. The private facilities have relatively high cost than the public facilities. The cost per unit of care for residents in institutional care are largely determined by number of factors which include: the functional status of the older person, capacity to do activities of daily living, capacity to obtain instrumental activities of daily living, mental and cognitive alertness among others. It is imperative to note that the cost per unit of care greatly hinges on the individual needs. Care provisions in these facilities ranges from psychosocial services such as depression and suffering from social diseases such as bereavement, loneliness among others; and medical care particularly diseases and ailment that are associated with the elderly such as arthritis, dementia, Parkinson's disease among others. Since the need of individual resident varies, thus, the care required will definitely be individualized and the cost of care would be varied from one resident to another.

The residents of these facilities were observed by this study to be in two categories. First are those who use the facilities exclusively for social reasons such as loneliness, isolation, boredom among others. This category of the elderly does not necessarily have any challenges of self-care that would require huge attention. The second categories are those who use the care facilities as a result of functional and cognitive disabilities. The definition of functional disability includes the inability of the elderly to be able to move on their own, do self-care, obtain the requirements of daily needs and attend to call of nature without help, while cognitive disability refers to the inability to comprehend, reason, remember and express correct sense of judgement to situation as result of conditions such as dementia among others. This category of the elderly may require large attention of care and presence of care attendants at all times to function.

Table 4.6: Distribution of Mean of Cost of Utilisation of Residential Care Facilities

Private	N	Minimum	Maximum	Mean	Std. Deviation
Cost of utilization	18	50000	135000	100000.00	25437.351
Valid N (listwise)	18				
`Public	N	Minimum	Maximum	Mean	Std. Deviation
Cost of utilization	2	45000	55000	50000.00	5037.351
Valid N (listwise)	2				

Table 4.6 describes the average cost of utilising residential care facilities in southwestern Nigeria. The table reveals the estimated minimum and maximum costs that residents who use the care facilities for social reasons may spend on their care in the facilities. For private homes, the minimum cost of care in the facilities is 50,000 naira and the estimated maximum cost is put at 135,000 naira per month while for public home, the estimated minimum cost is put at 45,000 naira and the maximum is estimated at 55,000 naira.

It is imperative to note that the facilities have standards different from one another in terms of amenities provided and services offered. Hence, the cost of care is not expected to be uniform across the facilities. While investigating the average cost per unit of care for the elderly in institutional care facilities in southwestern Nigeria on a monthly basis, it was revealed that the mean score of cost per unit of care for the elderly in public owned facility for residents who do not require specific medical care is #50,000, while residents in this category at privately owned facility pay an average cost of #100,000. It is pertinent to note here that some of the residents in public owned facilities are taken care of by public organizations and charity/ philanthropist group; others use funds and support from religious organizations and NGOs. Only a few of them pay for their cost of care by themselves or by their families.

Conversely, residents who require special care as a result of functional and cognitive impairment may have to pay relatively higher cost that will take care of their incapacities; such residents may require the services of consultants and other medical experts to help them recuperate from their ailing conditions. It is however difficult to determine the cost of care for these residents as their expenditure is determined by the frequency of use of the special services they require.

The study investigated the affordability of the care facility among the residents and family members responsible for their cost of care. The study found out that majority of the residents considers the cost of care in the institutional care facilities to be relatively expensive. Focused Group Discussion among residents who use the care facility exclusively for social reasons revealed that cost of living in the homes is unaffordable without a strong support and a source of income from family members. A respondent commented

> Living here is very expensive, my children pay between #80,000 and #100,000 every month for my staying here. Thank God for them, I don't know how I would have been able to afford this cost (FGD 08, 12/08/2018).

The implication of this shows that institutional care facility provision for the elderly incur huge expenses for the family members responsible for the care of their elderly. The finding of this study is in consonance with the report of Khongboon and Pongpanich, (2018) that services rendered at institutional care facilities are numerous and may greatly influence high expenditure on care as may be demanded by the need of the residents.

Research Question Seven: What is the process and quality of care in the existing institutional care facilities for the elderly in southwestern Nigeria.

The study investigated the process and quality of care among staff and residents of institutional care facilities in south west Nigeria. Majority of the respondent particularly the staff of the care facilities described the care process to be all-encompassing. Thematic analysis of the Focus Group Discussion and Interviews categorized the processes of care into three types, which include: Individualized care, Routine care and Flexible care. The study gathered that residents who are exclusively using institutional care facilities for social reasons have been classified as recipient of flexible care because they require less specific attention. The flexible care allows the residents for more independence and they were able to do their personal care themselves. In any case, resident that fall into this category of care do not have challenges of incapacities to do activities of daily living or instrumental activity of daily living. Further, the flexible pattern of care affords the residents of wide range of activities, which would accommodate their socio-cultural needs. A respondent noted:

> Pattern of care for people who do not have cognitive or functional impairment is usually flexible. We allow them to do their self-care though with close monitoring and make choices as they wish. Some of them will even tell you they want to attend parties or ceremonies and we don't deny them so long it will not affect their state of well-being (IDI 05, 29/07/2018).

This flexible pattern of care varies in implementation across the facilities. In some facilities, the flexible pattern of care was based on the inclusion of residents in decision-making. Choices of residents were greatly considered and therefore maximizing their capacities. However, this care process has been noted to be difficult and challenging, time consuming and commitment driven. One of the respondents commented:

> It is difficult to monitor the elderly when you allow them to take decisions on their own. At times they could be more frustrating that you may have to stop them from doing certain things. It stresses you more to monitor them and ensure they don't engage in activities that would put them at risk (IDI 09, 16/08/2018).

This flexible pattern of care was more tolerated in the public institutional care than the private institutional care facilities. In some of the facilities, both public and private, routine pattern of care is usually adopted. This pattern of care is focused on specific highlighted

activities for the residents on daily basis and it is usually task oriented. It is mostly focused on physical aspects of care, periodic medical assessment and periodic need evaluation. The routine pattern of care is mostly common in the western world; in other words, it is a western prototype of care for institutional residents among the elderly (OECD, 2005). Some of the providers of care facilities express desire to change the routine pattern of care to be able to accommodate socio-cultural demands of the residents; but they were challenged by the management of the residents with specific functional and cognitive impairment.

However, what some of the facilities resolve at is to modify the routine pattern of care to accommodate some socio-cultural needs and activities as part of the routine for residents. One of the respondents noted:

> We would have loved a situation where all residents would be able to participate in many socio-cultural activities such as community participation, committees in churches, gardening and so on as they wish, but those that have ailing conditions and require specific attention may be constrained. So, we need to make sure that their routine activities are done…" (IDI 01, 26/07/2018).

Some of the institutional care facilities also adopt individualized care pattern. This pattern of care sees every individual resident as unique and their specific needs are attended to. Although this pattern of care seems to be relatively expensive, it pays more attention to every individual resident with respect, dignity and sense of humour. With the individualized care pattern, each resident has his/her own care plan to meet their specific needs.

The pattern or process of care adopted by the institutional care facilities varied between these three categories of care process. In the public homes, the routine and flexible patterns of care are mostly employed. Of a fact, all the public homes sampled by this study used mostly the two patterns of care. On the other hand, some private institutional care facilities were seen to operate the three categories of pattern of care depending on the nature and need of the residents.

On the part of the residents, their choices and opinions on the pattern of care were sort. Table 4.8.1 describes the responses of the residents in percentages on the care processes provided in the facilities.

Table 4.8.1 Percentage responses of residents on care services provided

DOMAINS	ITEMS	YES (%)	NO (%)	MISSING (%)
Care Services	Are you generally satisfied with the care provided?	81	12	07
	Are you involved in the decision about your care?	68	26	06
	Have you been able to make choices about your care?	62	31	07

When asked about their satisfaction with the care provided in the facilities, 81% of the respondents express satisfaction on the process of care provided, while 12% expresses dissatisfaction. Although this positive expression of satisfaction may be relative as a form of resolve to accept the reality of living in the home and come to term with the fact that they may little or no option than to accept the care provided in the facility. A participant noted:

> The care process is not bad, but you know when you have to live with other people and under the control and guidance of some persons, you may have limited activities as you wish, but over the time, you will get adjusted and accept the reality (FGD 02, 26/07/2018).

This response shows that the resident might have come to the reality of accepting the pattern and process of care provided in the home. Also, when the residents were asked about their involvement in the decision of care, 68% of the respondents responded positively that they were being involved in the decision about their care. On the other hand, 26% denied being involved in the decision about their care. It could be inferred that majority of the institutional care facilities have adopted the flexible and individualized pattern of care as these were apparently the processes of care that afford the residents of being involved in decision about their care. Similarly, the residents were asked if they had opportunity to make informed choices about their care, 62% of the respondents responded in affirmative while 31% of the respondents responded negatively. This further confirms the inference on the process and pattern of care to be flexible and individualized.

Quality of care in institutional care facilities in southwestern Nigeria bothers on the quality of services, facilities and staff resources provided at the facilities with the satisfaction of the residents on the services provided. The study investigated the opinions of the users of the care facilities and it found that significant number of residents expressed satisfaction with the quality of care provided.

Table 4.8.2 Percentage responses of residents' opinion on quality of care

DOMAINS	ITEMS	YES (%)	NO (%)	MISSING (%)
Quality of Care	Do you have a personal room?	27	70	03
	If no: do you issues with sharing a room?	31	60	09
	Do you get adequate privacy?	66	32	02
	If no: are there places you can use for private moment?	17	78	05
	Do you think the care given to you is good?	61	28	11
	Is it comfortable here?	79	12	09
	Do you feel safe?	84	11	05
	Do you think your life changed for better since you came here?	71	20	09
	Do you think life has been worst since you came here?	16	81	03

Table 4.8.2 shows the items and responses of residents on the policy of care provided in the various facilities. The table revealed, among others that 79% of the respondents stated unequivocally that they were comfortable in the care facilities, 84% expressed that they felt safe within the facility, 66% claimed to have enough privacy, 61% described the care provided to be good and 71% stated that their lives have changed for better since they moved to the facility. The implication of this therefore, is that there is evidently appropriateness of care for the residents of these facilities and the residents expressed satisfaction to the care. This finding corroborated Donabedian's work on the quality of care (Donabedian, 1980). It is therefore sufficed to infer that the appropriateness of care is a function of the services available that is needed to attain and sustain the wellbeing residents on one hand and the acceptance of the care of the recipients that is, the residents of the care services provided.

Meanwhile, there are many factors that may enhance or improved the quality of care. These factors include but not exclusively limited to: staff resources, facilities, relationship with care providers, continuity with old lifestyle among others. The study investigated further on the residents' opinion of the staff resources in the facilities. It gathered that most of the residents posited to have very good and working relationship with the care providers. 89% of the respondents asserted that the caregivers in the facility are friendly, 91% of the respondents expressed that staff treat them with lots of respect, 77% posited that caregivers relate with them gently, for example when lifting them and 82% asserted that caregivers protect their modesty (Table 4.8.3).

Table 4.8.3 Percentage responses of residents' opinion on relationship with staff

DOMAINS	ITEMS	YES (%)	NO (%)	MISSING (%)
Relationship with Staff	Do staff treat you with respect?	91	06	03
	Do staff treat you gently, for instance, when helping you to sit-up?	77	19	04
	Do staff consider the protection your modesty? For instance: Knock on the door before entering your room.	82	11	07
	Are staff friendly with you?	89	09	02
	Do the staff know you well enough?	75	19	06
	Are your likes and dislikes known by the staff?	69	22	09
	Are your wishes respected by the staff?	72	26	02

The respondents apparently showed considerate satisfaction of services rendered by the facility providers. A participant noted

> …the staff here treat us with lots of respect. I am comfortable with many of them and I can relate my personal problems with them… (FGD 06, 02/08/2018)

Majority of the respondents seem to have cordial relationship with the care providers in the facilities. They practically bonded with them and relate with them like families. While investigating the relationship with the caregivers, the study gathered through survey that most of the respondents do not have problem of relationship or interactions with the caregivers in the facility. 70% of the respondents posited that the caregivers know them well, while 69% asserted that the caregivers know their likes and dislikes. This implies that the residents have cordial interactions with the caregivers. While considering the level of interactions with the caregivers, 52% of the respondents affirmed that the caregivers take time to listen to them while about 42% stated that the caregivers take time to chat with them (Table 4.8.3).

Summarily, there is an observed family pattern relationship between the residents and staff in the care facilities in southwestern Nigeria. Perhaps, this is due to the fact that the care facilities provide residence and complete care which include companionship for the residents, hence there has been a logical bonding between them. In other word, the care providers in these facilities have taken the role of family members, friends and confidants. One of the respondents commented,

> These people here are the ones with our needs and they have been doing their best in taking care of us. When I first came here, I was having issues with few of them, but later on we became best of friends. I see them more like my children (FGD 10, 28/08/2018).

This is pointing to the fact that overtime, relationship grows and people tend to accept one another. Gaylard, (2012) earlier posited that the support and relationship pattern that family members keep with their elderly have positive influence on their wellbeing. Those with cognitive challenges were also reported to recuperate fast due to the attention gotten from their relative. This kind of family relationship was observed between the residents and staff of the care facilities and this is expected to improve the wellbeing of the residents. Though the relationship grows overtime as those who have spent longer periods in the facilities tend to form better bond of interaction with the staff of the facilities.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The number of the elderly is increasing and there is a growing concern on the care provision for them. This is because there is already a rising pressure on the society's capacity to meet the need of the elderly as the traditional family system that hitherto takes care of the need of the older person has weakened. It is against this background that this study investigated the institutional care facilities provisions for the elderly in southwestern Nigeria with a view to determining the current stance of institutional care facilities in our contemporary society among other myriads of issues begging for answers on the provisions of institutional care facilities for the elderly. The study was presented in five chapters with the first chapter introducing the study, which include the background to the study that introduced the general concerns of the study and presented issues that gave the need to raise probing seven research questions for the study. It further identified the vacuum in literature that justified the need for this study. Chapter one also contained the statement of the problems, the objectives of the study, the research questions, scope and significance of the study and operational definition of terms.

There was a detailed review of relevant literature on the various concepts of the study. It presented issues as they concern the elderly, means of meeting the need of the elderly, care provisions for the elderly, institutional care facilities for the elderly, among others. It further examined relevant empirical studies available in literature and x-rayed the positions of scholars as the concern the elderly and institutional care facilities provisions. The study also considered some theories that are relevant to the elderly and institutional care facilities provisions to reinforce the configured thoughts in the study. Through the careful review of concepts, theories and empirical studies, the study was able to articulate a model for the understanding of related variables in the study and gave a justification for the model. The descriptive survey design was adopted by the study and a mixed method of data collection was employed. The multistage sampling procedure was adopted by this study and comprises four sampling techniques. A total of twenty institutional care facilities across the southwestern Nigeria were sampled. Also eighty-four (84) the elderly who are residents of

institutional care facilities in southwestern Nigeria and one hundred and eighty outpatients (180) who fall within the inclusion criteria of the study were used as participants in the first category, Staff of the facility care providers were sampled in the second category and family members who are responsible for the care of the elderly were also sampled. Questionnaires were used to collect data quantitatively while focus group discussions, key informant interviews and in-depth interviews were used to gather data qualitatively.

Descriptive statistical analysis of data was done to yield charts and percentages of frequency counts and logistics regression was employed in order to analyse the quantitative data; while the qualitative data was analysed with content analysis. The study presented the results and discussions that follow in this chapter. It summarily found that institutional care facilities provision is imperative to cater for the plethora challenges ravaging the elderly population, particularly those with challenges of functional and cognitive incapacities. Some of the findings are thus enumerated as follows:

- The socio-cultural disposition to institutional care facilities provision is changing and there is considerably more acceptance particularly from the elderly and their family members.
- Demographic, social and health factors are the major factors influencing the utilization of institutional care facilities.
- Majority of the institutional care facilities established were owned and managed by Christians.
- The institutional care facilities currently established in southwestern Nigeria have low capacities.
- Majority of the care facilities were not purposely built for institutional care provision and this has continued to hamper on the quality of care provided.
- Most institutional care facilities provided are owned by private individuals or groups.
- There is no policy document and legal framework that would guide the provision of institutional care facilities in south west Nigeria.
- The cost of care in institutional care facilities in south west Nigeria is relatively expensive. The average cost of care in the public facilities is ≥₦50,000 while that of private facilities is ≥ ₦100,000.
- A tripartite pattern of care is usually adopted in the existing institutional care facilities and these include the flexible, routine and individualized patterns of care.

- Most of the residents of the care facilities expressed moderate satisfaction with the care services provided.
- Majority of the residents of the care facilities have either functional or cognitive incapacities or both. Less than 25% of the residents use the facilities exclusively for social reasons.
- Most of the facilities were provided for business purposes as it appears as unexplored area in the social and medical care industry.

5.2 Conclusion

Institutional care facilities provision for the elderly is gradually becoming popular and our society is consciously accepting its significance given the changes in the societal structure. Societal dispositions have become individualized and positions were held based on the views and stake of the person in focus. Most people, inadvertently, take positions that institutional care is not acceptable without considering the plight and realities confronting the elderly. With the evidences available to this study, institutional care facilities provision is a necessity to address the challenges of social, functional and cognitive incapacities combating the teeming population of the elderly. Most of the elderly in the category of old-old, that is, those above the age of 80 years are the ones who may greatly be in need of these facilities and those who particularly have challenges with functional and cognitive capacities.

With the change in societal dispositions as evident in the increase in the provisions observed between 2007 and 2017, and the conscious acceptability of the use of the facilities observed by this study, there is the plausibility of further increase in the provisions as the number of the elderly increases and the need to care for them arises. More patronage to the care facilities would be experienced and this would put more pressure on the capacity of the existing institutional care facilities. Further, lack of policy framework to guide the provision of institutional care facilities is a major setback and great disservices to the teeming population of the elderly. The legal framework is expected to provide impetus for operational guidelines which would be used by the current and intending care providers with a view to monitoring and regulating the process, pattern and quality of care in the institutional care facilities.

It is also evident that the major characteristics influencing the use of institutional care facilities are majorly the demographic characteristics and health related factors encumbered by the inability to do self-care. Although, a figment of the users of the institutional care facilities does so for social reasons, however, the percentage of such the elderly is low.

Hence, institutional care facilities may just be the appropriate interventions for the elderly threatened by frailty and functional and cognitive incapacities. Similarly, since it will ease the burden of care from the family members that provide care for the elderly, it will be most appropriate for use to help the members of the family focus on other important things.

Finally, the process of care observed in some of the institutional care facilities seems appropriate for the socio-cultural needs of the residents. These are the facilities that have complementary cultural meanings that create a home-like environment for the residents and afford them the varieties of activities which they would naturally have accessed to if they were to be in their homes. Although not all the institutions have these facilities; this deficiency would have been remediated were there policy guidelines that would specify the modus operandi in the care facilities.

5.3 Recommendations

Based on the findings of this study, the following were recommended:

- Stakeholders in the gerontology industry should provide more public enlightenment on the supposed aspersions cast on institutional care facilities as a dumping site ofthe elderly to die. However, this perception is gradually weaning off, more efforts would help in the total eradication of the thoughts.
- There should be periodic sensitization of the public by the institutions on the roles, functions and services they provide for the elderly to create more acceptability of the facilities among the much younger generation. The institutions should be opened to visits for the public; particularly, the children and interest groups. This would expose the public to the significance of the institutions.
- There should be specific legal framework promulgated and enforced by government mercenaries to address the exclusive issues of institutional care facilities provision. A brief guide provided by this study could be a leading help to developing this framework.
- Given the prevalent need of institutional care provisions for the elderly, it is imperative for government to invest more in the provision of institutional care for the elderly to provide functional alternatives to the private homes.
- Health insurance institutions should develop framework that could afford future contingences for the plausible use of institutional care for the elderly and provide finances for the care when the need arises. This would ease the burden of care

expenditures on the elderly who may not have family members to cater for their care at old age.

- Since the major determinants of institutional care facilities are functional and cognitive incapacities, care providers should give more attention to medical care services and employ more services of professional care providers, registered nurses and paramedics.
- There should be appropriate consultation structures in the institutional care facilities to take care of specific socio-cultural needs of the residents particularly where such services are not available. Residents should be able to lend their voice on those specifics and proper attention to be given to them.
- Buildings that were not specifically designed for the purpose of care facilities should be renovated to suite the appropriateness of use so as to reduce the pressure of movement on residents and care providers.

5.4 Contributions to knowledge

The study has been able to contribute the following:

- The study developed a guideline on basic minimum requirements for the provision of residential care facilities based on the findings of this study (see Appendix seven).
- It brings to fore that deficiencies in physical structures and other care capacities were largely due to the unavailability of policy framework that would guide the provisions of care.
- The study classified pattern of care for the elderly summarily into three which include, the flexible, routinised and individualised patterns of care.
- The pattern mostly used are flexible pattern, which accommodate the traditional pattern of care, the routine pattern which is a prototype of the western pattern of care and this is mostly for the significantly impaired residents; and the individualise pattern which is a blend of the flexible and routine pattern of care.
- Against the popular position in literature that institutional care facility is alien to Nigerian culture and not acceptable, the study has established that this notion is an archaic thought as institutional care facilities is gradually getting vast acceptability among the elderly and their families. Furthermore, socio-cultural disposition is also changing as there is a growing trend of individualised perspectives and social apathy in the contemporary Nigerian society particularly in the Southwest.

- Inclusion of socio-cultural needs of the residents and a blend of our traditional value system into the care processes for the elderly would make the institutions more acceptable.
- Functional and cognitive impairments and age, specifically among those in the category of old-old (80 years are above) are the strongest factors influencing the use of institutional care facilities.
- The significance of income, education, bereavement and bareness as factors influencing the use of institutional care were discarded as these factors were barely present among the characteristics found in residents of institutional care facilities in southwestern Nigeria.
- Institutional care provision is a viable business hub in the social and health care industry as there are huge patronages of the existing ones.

5.5 Policy Implications

It is evident that there is need to do more work on the provisions of institutional care facilities for the elderly. No effort has been put together by policy makers to provide for the institutional facilities in policy documents across the country. There is the need to give prominent attention to the establishments and management of institutional care facilities for the elderly. Specific attention has to be given to issues bothering on the establishment of the facilities and care provided. Focus should be on admission, standard of care, contract of care, welfare and wellbeing of residents, personal possession, discharge planning and regulations, staffing, accommodation and facilities, structure designs, hygiene, sanitary facilities, nutrition, records, medical care, death and dying or end of life care, inspections, channel of complains among others. The responsibility and impetus are on the government and every stakeholder in the gerontology industry to ensure appropriate measures are put in place for the provisions of institutional care facilities for the elderly.

5.6 Limitation of the Study

The researcher encountered a number of challenges in the course of the study. Obtaining ethical approval for the study was very tedious and time consuming. Given the scope of the study, that covers the whole of southwestern Nigeria, the researcher found it financially and administratively challenging to survey the geographical scope. It was a little more difficult to get the institutional care facilities providers to consent to the study. It took a lot of persuasion, patience and resilience to get the residents to attend the focus group

discussion sessions. Administering the questionnaire was also challenging, as most of the elderly could not complete the instrument on their own. Attrition also became a challenge to contend with.

5.7 Suggestions for Further Study

The focus of this study was restricted to south-western Nigeria, subsequent study should be done in institutions in other geo-political zones in Nigeria. Further studies should also be focused on satisfaction with the quality of care and life satisfaction of the elderly in institutional care facilities in Nigeria.

REFERENCES

Aboaba O.I 2003. Assessment of Nutrition Status for the Elderly in Ogun State Nigeria'.Unpublished Ph.d. Thesis in the Department of Human Nutrition Faculty of Public Health In Partial Fulfilment of the Requirement for the Degree of Doctor of Philosophy University of Ibadan.

Adedayo I. 2015. States Still on Implementation of New Pension Act. *Punch Newspaper* April, 27:36

Adedeji M. A. 2008. Comparative analysis of indigenous social welfare practice for the aged Ewe of Ghana and Yoruba of Nigeria. Ph.D Thesis in the Department of Adult Education, University of Ibadan.

Adelowo A. O. 2000. The Problems of Ageing and the Aged in Nigeria. *Social Problems and Social Work in Nigeria*. Lagos; Centre for Planning Studies, Lagos State University.

Aderegba A. A. 2015. Pensioners to Pickets Accounts General's Office Over Arrears. *Saturday Punch,* October, 31:51

Adesomoju A. 2016. 80- year Old Buhari's Daughter, 2, 216 Others Join Nigerian Bar. *The Punch*, July, 15:10.

Adewale A. 2015. Mieko Nagaoka at 100 years old completed 1,500 meters of Swimming Competition in Japan. *Tell Magazine*, May, 11:10

Adewale A. 2015. Illegal to Abandoned Parent in China. *Tell Magazine.* Jan, 11:10

Adewale A. 2015. Oldest touch bearer. *Tell Magazine.* November, 23:11

Adewale A. 2015. Harry Nelson 90 years old 18 times at Olympic. *Tell Magazine.* November, 23:11

Adeyemo T. 2011. Bone Cancer on the Rise. *TELLMagazine*. August 12:12

Adeyi Y. 2015. Police Arraign 80 – Year old, Others for Possession of Arms. *Saturday Punch* May, 4:5

Age Concern 2003. *Adding Quality to Quantity: Older People's Views on Quality of Life and its Enhancement*. London: Age Concern.

Age Concern 2008. *Undiagnosed, Untreated, at Risk: The Experiences of Older People with Depression*. London: Age Concern.

Aikhoje, S. O. 2006. Influence of Personal and Psycho Social Factors on Satisfaction with Retirement Life of Retirees from selected Federal Universities in Southern Nigeria. Unpublished Ph.D Thesis in the Department of Adult Education, University of Ibadan. Vi+184.

Aikhoje, S. O. 2013. *Work, Retirement and Graceful Ageing Reflections on Work Retirement and the Final Phase of Life*. Ibadan: AgboAreo Publishers

Aiyejine, T. 2011. Nwobum's Family: UA Tale of Wooes, Suffering rest. *The Punch Newspaper* July 9:58.

Ajala T. 2015. Want to Boost Your Brain Power? Try Regular Sex. *Saturday Punch*. May, 2:3

Ajomale, O. 2007. Elder Abuse: The Nigerian Experience. Retrieved March 10, 2017 from http://www.inpea.net/images/YinkaPaper_ElderAbuse_Nigeria_Dec07.pdf

Ajomole O. 2006. *Elder Abuse Family Violence Exposed*Ibadan. Hadassah Publication

Ajulu O. 2015. I wept the day I saw 92 year – old Nigerian in Prison for Drug Offence. *Saturday Punch.* December, 9:38

Akenzua N. 2015. Blind Man 71, Slaps Pregnant Daughter in Law over Meal. *Sunday Punch*, November 11:6

Akenzua N. 2015. Delta Retirees Protest Unpaid Pensions as Members Die. *Sunday Punch*. October 18:4

Akeredolu- Ale E.O and Aribiah O. 2002. *Public Policy and Old Age Security in Nigeria*. Ibadan. Centre for Social Policy

Akinsola M.K and Ogunleye B.O. 2000. Statistical Methods and Research Design. In *Education: An Introduction.* Department of Teacher Education, University of Ibadan.

Akinyele S. 2015. World Wearable Robots Haz –Hybrid Hal – Hybrid Assistance Limb. *Tell Magazine.* June 15:7

Akpokona, O. 2010. Okpe Pensioners Decry Non- Payment of Benefit. *Vanguard Newspaper* September,17:11.

Alebisu N. 2011. 100 years Old Completes Marathon. *Nigerian Tribune*, October, 18:53

Amaike B. 2009. *Education as a Correlate of Life Satisfaction among Retired Older People in Lagos State, Nigeria*. Department of Sociology, Faculty of Social Sciences, University of Lagos, Nigeria

Andersen, R. and Newman J. F. 1973. Societal and Individual Determinants of Medical Care Utilization in the United States, Milbank Memorial Fund Quarterly. *Health and Society* 51(1): 95–124.

Andersen, R. M. 1995. Revisiting the behavioral model and access to medical care: does it matter? *Journal of health and social behavior* 36: 1–10.

Andersen, R. 1968. *A Behavioral Model of Families' Use of Health Services. Centre for Health Administration Studies.* Research Series 25. Chicago: University of Chicago.

Arber, S. and Ginn. J.1991. *Gender and Later Life: A Sociological Analysis of Resources and Constraints.* London, Newbury Park, New Delhi: Sage Publications.

Asom J. 2011. How Blues sent Pa Okunsanwo to the Graves. *Vanguard* October 31:63

Ate O. G. 2014. Socio-demographic determinants of elderly wellbeing in Ijumu local government area of Kogi State, Nigeria. Ph.D Thesis in the Department of Public Health, University of Ibadan.

Awoyinfa S. 2015. Federal Pensioners Protest Non-Payment of Benefit. *Punch Newspaper.* May, 8:6

Aybonkhere J. 2016. You Cannot maltreat our Senior Citizen. *Sunday Vanguard*. June, 6:14

Ayeleso, O. 2010. New Pension Scheme; Artisans Claim Ignorance. *Nigerian Tribune*. September, 3:35.

Bachand, L.L and Caron, S. L, 2001. Ties that Bind: A qualitative Study of happy Long term Marriage. Contemporary family therapy. *An International Journal* 23. 105-121.

Bakare O. 2015. Fashola and Lagos Pensioners. *Punch Newspaper.* May, 8:23

Bakare, W. 2009. An Ageing World 2008. *The Punch Newspaper*. August 24:3

Bamgbose, A. 2006. Unpaid Pension Will Frustrate FG's Anti – Corruption War. *Punch Newspaper.* February, 28:51.

Barrett, A.E. and Cantwell, L.E. 2007. Drawing on stereotypes: Using undergraduates' sketches of elders as a teaching tool. *Educational Gerontology,* 33(4), 327-348.

Beeston, D. 2006. *Older People and Suicide*. Birmingham/Stoke on Trent: CSIP West Midlands/Staffordshire University.

Bengtson and Dowdy J 1997. *Theory, Explanation, and a Third Generation of Theoretical Long Time care System*. Washington, D.C: American Association of Retired persons

Bengtson V, Tonya P and Burgess E.1996. Progress and Pitfalls in Gerontology Theorizing. *The Gerontologist* 36:768-72.

Berry, C. 2011. *Past Caring? Widening the Debate on Funding Long Term Care*. London: International Longevity Centre. www.ilcuk.org.uk (accessed 9 August 2016).

Bessa ME, Silva MJ, Borges CL, Moraes GL, andFreitas CA 2012. Elderly residents in long-term institutions: the use of spaces in the construction of everyday life. *Acta Paul Enferm* 25(2):177-82. Available from: http://www.scielo.br/pdf/ape/v25n2/en_a04v25n2.pdf

Bisiriyu, R. 2009. Railways Retirees Awaits 25 Months Pensions, Recount Ordeal. *The Punch Newspaper.* November, 11:38.

Blair S. N., Kohl H.W., Paffenbarger R.S., Clark,D.G, Copper, K.H, and Gibbons, L.W 1989. Physical Fitness and all –cause Mortality: A Perspective Study of Healthy Men and Women. *Journal of the Americans Medical Association* 262, 2395-2401.

Blau, P.M 1964. *Exchange and Power in Social Life.* New York: Wiley

Bless C., and Achola P. W. 1987. *Fundamentals of Social Research Methods: An African Approach.* University of Zambia.

Bloomer, M., Cross, W., Endacott, R., O'Connor, M. and Moss, C., 2012. Qualitative observation in a clinical setting: challenges at end of life. *Nursing and Health Sciences*, 14(1), 25-31. doi: 10.1111/j.1442-2018.2011.00653.x

Bowling, A. 2005. *Ageing Well: Quality of Life in Old Age*. Maidenhead: Open University Press.

Bradshaw, A. and Merriman, C. 2007. Caring for the elderly. England: John Wiley and Sons

Bulugbe T. A. 2013. Physical Exercise: An Elixir for Healthy and Active Ageing 3rd Inaugural lecture. Tai Solarin University of Education. Ijagun, Ijebu-Ode.TaiSolarin University of Education press.

Caird, F.I. and Grimley Evans, J. 1995. Medicine in old age, in D.J.Weatherall, J.G.G. Ledingham and D.A.Warrell (eds), *Oxford Textbook of Medicine*, vol. 3, Oxford University Press, Oxford, pp. 4333–6.

Calnan, M., Badcott, D. and Woolhead, G. 2006. Dignity under threat? A study of the experiences of older people in the United Kingdom. *International Journal of Health Services* 36(2): 355–75.

Carnes ,B.A Olshansky, S. J. Gavrilov, L. Gavriola and Grahn, D. 1999. Human Longevity: Nature vs Nurture fact or fiction. *Perspective in Biology and Medicine,* 42, 422-441.

Caro, F.G, Bass S.A and Chen V. P. 1993. *Achieving A productive Aging Society*. Weastport, CT: Auburn House.

Carriere, Y. and Pelletier L. 1995. Factors underlying the institutionalization of elderly persons in Canada. *The journals of gerontology. Series B, Psychological sciences and social sciences* 50(3): S164–72.

Chater, K. and Tsai, C., 2008. Palliative care in a multicultural society. *Australian Journal of Advanced Nursing*, 26(2), 95–100. http://www.ajan.com.au/Vol26/26-2_Chater.pdf

Choi, Y. 2003. The study on depression, selfesteem, and health behaviors in the elderly. *Journal of Welfare for the Aged*, Fall, 03.

Coward, R. T., Netzer, J. K.and R. A. Mullens R. A.. 1996. Residential differences in the incidence of nursing home admissions across a six-year period. *The journals of gerontology. Series B, Psychological sciences and social sciences* 51(5): S258–67.

Cowgil, D. 1974. The ageing of the Americans Academic of Political and Social Sciences 415{29]; 1-18.

Cumming, E. and Henry, W 1961. *Growing Old: The Process of Disengagement*. New York: Basic Book.

Dennis, M., Baillon, S., Brugha, T., Stewart, R., Meltzer, H. and Lindesay, J. 2007. The spectrum of suicidal ideation in Great Britain: comparisons across a 16–74 years age range, *Psychological Medicine* 37(6): 795–805.

Development in Special Gerontology. *Journal of Gerontology, Social Sciences*. 52B(2), 572-588.

DH (Department of Health) 2010. *Improving Health and Well-being of People with Long Term Conditions. World Class Services for People with Long Term Conditions: Information Tool for Commissioners*. London: Department of Health.

DH (Department of Health) 2010. *Long Term Conditions*. Available at: http://www.dh.gov.

Dolgoff R. and Donald F. 1980. *Social work: Understanding Social Welfare*. New York: Harper and Row.

Dominy, N. and Kempson, E. 2006. *Understanding Older People's Experiences of Poverty.*Brace. Jovanovich.

Donabedian, A., 1980. *Explorations in Quality Assessment and Monitoring*. Ann Arbor, MI: Health Administration Press.

Dumo. E. 2015. Son Mummifies Dead Mother to Claim her Pension for three Years. *Punch Newspaper.*October, 31:50

1Duru, N. 2009. Adopts Germa1n Investment Model, NLC Tells Pencom. *ThisdayNewspaper* March, 25:30.

Egunyomi, D. A. 2012. The Adults and Aged: The Nigerian situation. In Osinowo, H. O, Moronkola, O. A and Egunyomi, D. A (Eds). *The Adults and Aged in Nigeria: Issues and Researches.* Ibadan: Royal People, 1-16.

Einio E. K. 2010. Determinants of Institutional care at old ages in Finland. *Finnish Yearbook of Population Research* XLV 2010. Finland: Population Research Institute

Emmanuel, O. 2010. Misery as Colony of Abandoned Old People Swells. *The Punch*. June 6:8.

Erickson, E.H, Erickson, J.M and Kivnick, H.Q, 1986. *Vital Involvement in Old Age*. New York: Norton

Evbuoma, I. K. 2012. Remediating the old people's home prototype by elder daycare facility: a concept in elderly care initiative for adoption in the Nigerian context. In Osinowo, H. O, Moronkola, O. A and Egunyomi, D. A (Eds). *The Adults and Aged in Nigeria: Issues and Researches.* Ibadan: Royal People, 30-41

Excell, S. 2010. Older people and dual diagnosis, in P. Phillips, O. McKeown and T. Sandford (eds.) *Dual Diagnosis: Practice in Context*. Chichester: Wiley-Blackwell.

Fanimo, D. 2007. Pensioners as Puns in Government's Chess Board. *Guardian Newspaper* October, 23:37.

Ferreira, M. 2005. Advancing Income Security in Old Age in Developing Countries: Focus on Africa. *Global Ageing* 2(3) 32-6

Finch, C.E 1998. *Variations in Senescence and Longevity include the possibility of Neglible Senescence*. Journal of Gerontology: Biological Sciences, 53 A,235-B239.

Fisher R. and Scragg T. 2012. Working with older people with long term conditions. In Barbara Hall and Terry Scragg (Eds.) *Social work with older people: Approaches to person-centered practice*. England: Open University Press. 129-144

Foley, D. J., Ostfeld A. M., Branch L. G., Wallace R. B., McGloin J., and. Cornoni- Huntley J. C. 1992. The risk of nursing home admission in three communities. *Journal of aging and health* 4(2): 155–173.

Fowora O. 2014. Nigeria Among Worst Places for Old People. *Sunday Punch.* December, 21:71

Freedman, V. A. 1996. Family structure and the risk of nursing home admission. *The journals of gerontology.Series B, Psychological sciences and social sciences* 51(2): S61–9.

Freund AM; 1997. Self-definition in old age. (German, abstract). Zeitschrift fur Sozialpsychologie; 28 (1-2); 44:59

Gachuhi J. M. 2002. *Teaching and Research In Gerontology.* Bureau of Educational Research Kenyatta University.

Ganagana M. 2016. 80 year Old Woman Butchered. *Daily SunNewspaper.* May, 7: 5

Ganiyu A. 2011. A Bitter-sweet Kola. *Tell Magazine.* December, 12:17

Gaugler JE, Duval S, Anderson K. Kane R. L. 2007. Predicting nursing home admission in the U.S.: a meta-analysis. *BMC Geriatrics* 7: 13.

Gaugler, J. E., S. Duval, K. A. Anderson, and R. L. Kane. 2007. Predicting nursing home admission in the U.S: a meta-analysis. *BMC Geriatrics* 7: 13.

Gaylard D. 2012. Working with older people with mental health needs. In Barbara Hall and Terry Scragg Eds. *Social work with older people: Approaches to person-centered practice*. England: Open University Press. 85-101

Gelfland D. E. 1984. *The aging network programs and services*. New York:Springer publishing company Inc.

George M. L. 2001. "Housing and Living Arrangements. in Binstock R. A and George L. K, (eds) *Handbook of Aging and the Social Sciences,* CA: Academic Press. 426-443

Glascock A. P 1980. Feinman SL. A holocultural analysis of old age. *Comparative Social Research,* 3:311-32.

Godfrey, M. 2009. Depression and anxiety in later life: making the visible invisible, in T. Williamson (eds.) *Older People's Mental Health Today: A Handbook.* Brighton: OLM-Pavilion/Mental Health Foundation.

Godfrey, M. and Denby, T. 2004. *Depression and Older People*. Bristol: Policy Press.

Gold, M. 1995. Hospice care allow Death with Dignity. Provider Summer.

Golden, J., Conroy, R.M., Bruce, I., Denihan, A., Greene, E., Kirby, M. and Lawlor, B. A. 2009. Loneliness, social support networks, mood and well-being in community dwelling elderly. *International Journal of Geriatric Psychiatry* 24(7): 649–700.

Gorman M. 2000. Development and the rights of older people. In: Randel J, et al., Eds. *The ageing and development report: poverty, independence and the world's older people.* London: Earthscan Publications Ltd.,1999:3-21.

Grimley E, J., Franklin W, T., Lynn B. B., Michel, J.-P. and Wilcock, G.K. 2000. *Oxford Textbook of Geriatric Medicine*. Oxford University Press, Oxford.

Grundy, E. 1992. Socio-Demographic Variations in Rates of Movement into Institutions among elderly People in England and Wales: An Analysis of Linked Census and Mortality Data 1971–1985. *Population Studies* 46(1): 65–84.

Grundy, E. and JitlalM. 2007. Socio-demographic variations in moves to institutional care 1991–2001: a record linkage study from England and Wales. *Age and Ageing* 36(4): 424–430.

Hall, K.W. and Batey, J.J. 2008. Children's ideas about aging before and after an intergenerational read-aloud. *Educational Gerontology,* 34(10), 862-870.

Hardwick S., Jennifer P., Elizabeth D, Aleske K. 1994. *Across the state 1994 Profile of*

Harrington, C. 1991. The Nursing Home Industry: A Structural Analysis. Critical Perspectives on Ageing: The Political and Moral Economy of Growing Old. NY: Baywood

Harris, J., Piper, S. and Morgan, H. 2003. *Experiences of Providing Care to People with Long Term Conditions*. York: Social Policy Research Unit.

Haruna, M. 2009. Still on Citizen Buhari's Plight. *The Nation Newspaper*. February, 25:20.

Havighurst, R. J., Bernice J, Neugarten L and Sheldon S. T. 1968. Disengagement and Pattern of Ageing. In *Middle Age and Ageing; A Reader in Social Psychology (Eds)*Neugarten Chicago: University of Chicago Press.

Hayslip, B and Leon J. 1992. Hospice Care Newbury Park: CA: Sage

Help Age International 2002. *Ageing Issues in Africa: A Summary.* London; Help Age International

Help Age International 2002. *State of the World's Older People 2002.* London; Help Age International

Help Age International August 2006. *Ageing and Development.* London; Help Age International.

Help Age International February, 2005. *Ageing and Development.* London; Help Age International

Help Age International January 2006. *Ageways*. London: Help Age International

Help Age International October 2003. *Ageing and Development.* London; Help Age International

Hirsch, J.K., Duberstein, P.R. and Unutzer, J. 2009. Chronic medical problems and distressful thoughts of suicide in primary care patients: mitigating roles of happiness, *InternationalJournal of Geriatric Psychiatry* 24(7): 671–9.

Homans, G.C 1961. *Social Behaviour: Its Elementary Forms*. New York: Harcourt

Hooyman N and Kiyak H.A 1996. *Social Gerontology: A Multidisciplinary Perspective.*Allyn and Bacon: Needham Heights Ma:

Hooyman, N. and Kiyak, H.A 1996. *Social Gerontology: A Multidisciplinary Perspective.* Needham Heights Ma : Allynand Bacon.

Ihuoma, C. 2010. F.G Begins Payments of 23bn Military Pension Arrears. *Punch Newspaper.* June, 23:8

Jackson, C. 2009. Older people, suicide and self harm, in T. Williamson (ed.) *Older People's Mental Health Today: A Handbook*. Brighton: OLM-Pavilion/Mental Health Foundation.

Jang, M. and Kim, Y. 2005. The relationship between stressors, depression, and suicidal thoughts in the elderly. *Mental Health Nursing,* 14(1)

Johnson L.C, Schwartz C.L and Tate D.S 1997. *Social Welfare A Response To Human Need.* Boston: Allyn and Bacon.

Kane, R.A., 2001. Long-term care and a good quality of life: bringing them closer together, *The Gerontologist*, 41(3): 293-304.

Kester, K. O, Adeyeye, J. O and Ogunyinka, K. O. 2007. Issues, challenges and policy implication of social security provision for the aged in Nigeria. *LASU Journal of Social Sciences,* 6 (1 and2): 146-164.

Kimuna, S.R., Knox, D. and Zusman, M. (2005) College students' perceptions about older people and aging. *Educational Gerontology,* 31(7), 563-572.

Kite, M.E. and Wagner, L.S. 2004. Attitudes toward older adults, in T.D. Nelson (eds.) *Ageism: Stereotyping and Prejudice against The elderly*. Cambridge, MA: MIT Press.

Klein T. and Salaske I 1994. Determinants of nursing home admission of elderly patients and chances for prevention. A longitudinal study in Germany. *Z Gerontology* 27: 442–55.

Klein T. 1996. Determinants of institutionalisation in old age. *Development Health Econ Public Policy*. 5: 103–13.

Lawton, M. P and Nahemow L. 1973. Ecology and the Aging Process. In: Carl Eisdorfer and M. Powell Lawton (eds.). *The psychology of adult development and aging*. Washington D.C.: American Psychological Association, 619–742.

Lawton, M. P. 1989. Behavior-Relevant Ecological Factors. In: Schaie K. W. and Schooler C. (eds.), *Social structure and aging: Psychological processes*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc., 57–78.

Layard, R. 2006. *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London: LSE.

Lemon, B., Vern. B, and James P. 1972. An Exploration of the Activity Theory of Aging: Activity Types and Life Satisfaction among in – movers to a Retirement Community. *Journal of Gerontology*. 27:511-23.

Levinson, D. J. 2008. *The seasons of a man's life.* Athens, Rome: Random House LLC.

Levy, B.R., Ashman, O. and Dror, I. 2000. To be or not to be: The effects of ageing stereotypes on the will to live, *OMEGA* 40(3): 409–20.

Lingsom, S. 1997. *The substitution issue: Care policies and their consequences for family care.* NOVA Rapport 6/97. Oslo: Norwegian Social Research.

Llewellyn, A., Agu, L. and Mercer, D. 2008. *Sociology for Social Workers*. Cambridge: Polity Press.

Luppa M., Luck T., Weyerer S., Konig H., Brahler E., and Riedel-Heller S., 2009. Prediction of Institutionalisation in the elderly: A systematic Review. *Age and Ageing*; 1(8) doi: 10.1093/ageing/afp202

Lyons I. 2009. Public perception of Old people and Ageing. *National Center for the Protection of Older People.* http://www.ncpop.ie

Makinde, F. 2015. Pensioners Ask CBN to Stop Osun N35bn Bailout. *Punch Newspaper.* September, 16:3.

McConatha, J.T., Hayta, V., Rieser-Danner, L., McConatha, D. and Polat, T.S. 2004. Turkish and U.S. attitudes toward aging. *Educational Gerontology*, 30(3), 169-183.

Meribe N. 2011. How Phone Application can Help the Aged. *The Punch*. May, 5:3

Mojeed, M. 2008. Pensioners Utomi Approach INEC foe Own Political Party, *The Punch*. January, 24:5.

Moody H.R 1998. *Ageing Concepts and Controversies*. Thousand Oaks. Carfolonia: Pine Forge Press.

Moreira-Almeida, A., Neto, F. and Koening, H., 2006. Religiousness and mental health: a review. *RevistaBrasileira de Psiquiatria*, 242-250

Morgan L and Kunkel S 2001. *Ageing: The Social Context.* California: Pine Forge Press.

Morgan, L. and Kunkel, S. 2001. Ageing: The Social Context. California: Pine Forge Press.

Muhammed, K. B. 2008. Pension Assert Grow to 970 Billion. *Guardian Newspaper.* November, 27:96.

Murphy K., O'shea E., Cooney A., Shiel A., and Hodgins M. 2006. *Improving quality of lives for the elderly in Long-stay care settings in Ireland*. Dublin: National Council on Ageing and Older people

Musaiger, A.O. and D'Souza, R. 2009. Role of age and gender in the perception of aging: A community-based survey in Kuwait. *Archives of Gerontology and Geriatrics,* 48(1), 50-57.

Mustard, C., M. Finlayson, S. Derksen, and J. M. Berthelot. 1999. What determines the need for nursing home admission in a universally insured population? *Journal of health services research and policy* 4(4): 197–203.

Muyana .C. 2009. Health care: Mid wives on A Mission to Save Mother Child. *Guardian Newspaper*. October, 25:16.

Muyana .C. 2009. Health care: Mid wives on A Mission to Save Mother Child. *Guardian Newspaper.* October, 25:16.

Nanada S. 1994. *Cultural Anthropology.* Belmont Californian: Wordsworth Publishing House.

National Bureau of Statistics 2014. *Focus on Older People*. London: ONS.

National Center for Health Statistics. 2009. *Health: United States, 2008*. Hyattsville, MD: U.S. Department of health and human services. Centers for Disease Control and Prevention, National Center for Health Statistics.

National Institute of Ageing, 2009. *An Ageing World 2008*. National Institute of Ageing: Chicago

National Institute of Health 2000. Obesity. In, Shils M.E, Olson J.A, Shike M, and Ross Baltimore A.C (Eds.) Modern Nutrition in Health and Disease (9th Edition), MD:Williams and Wilkins

National Population Commission (NPC) [Nigeria] and ICF Micro. 2009. Nigeria Demographic and Health Survey 2008. Abuja, Nigeria: National Population Commission and ICF Micro.

National Population Commission. 1998. 1991 Population Census of the Federal Republic of Nigeria: Analytical Report at the National Level. NPC, Abuja, Nigeria.

National Population Commission. 2004. Nigerian Population Census 1991 Analysis. Vol. 3: The Elderly. National Population Commission, Abuja, Nigeria. 2004.

Nihtila, E. and P. Martikainen. 2008. Institutionalization of older adults after the death of a spouse. *American Journal of Public Health* 98(7): 1228–1234.

Noelker, L.S. and Harel, Z., 2001. 'Humanizing long-term care: forging a link between quality of care and quality of life' in Noelker, L.S. and Harel, Z., (eds), 2001. *Linking Quality of Long-Term Care and Quality of Life*. Canada:

Nweke J. O 2015. Non-contributory pension scheme and the welfare of retired civil servants in Ebonyi State, Nigeria. Ph.D Thesis in the Department of Sociology, University of Ibadan.

Nwokolo E. 2011. Why we live long –Ijebu's 100 years-olds. *The NationNewspaper* February 5:14

O'Shea, E. and O'Reilly, S., 1999. *An Action Plan for Dementia.* Dublin: NCAOP.

OECD, 2005. *Long-Term Care for Older People.* Paris: OECD.

Ojaizo T. 2015. 80 – Year Old 71 Other Nabbed for Gun Running. *Daily Sun Newspaper.* October, 20: 6-7.

Oke D. I 2014. Effects of self management and bibliotherapy techniques on psychological wellbeing and life satisfaction of retirees in Ondo State. Ph.D Thesis in the Department of Psychology, University of Ibadan.

Okunbor K. 2015. N30b Pension Liabilities, Airlines Debts Threatens FAAN'S Operations. *The Nation Newspaper.* June, 3:25

Okunola M.I. 2002. A hand Book for Nigerian Social workers. Daybis Limited: Ibadan

Oladele, A. 2010. Pencom may commence sanction of employers over non-compliance. *Nigerian TribuneNewspaper*. August, 20:22.

Olayinka C 2011. Labour to meet Government on New Minimum Pension. *The Guardian Newspaper*, September 15:22

Olokor, F. 2015. F.G Orders Verification of Workers. Punch Newspaper, May, 8:7

Olumide, S. 2009. Forty- Seven Among us Have Died. *Guardian Newspaper* June, 16:15.

Omotayo O T. 2006. Gerontological Social Work and Contemporary Ageing. *Journal of Arts and Social Sciences*. College of Social and Management Sciences. Tai Solarin University of Education. 8 (1) 102-116.

Omotayo O. A 2010. Use of Traditional Seasoning as Means of Enhancing Taste and Acceptability of Food: Opinion of Selected Adult Christian Women in Ijebu Ode. *Nigerian Journal of Education, Planning and Finance.* 4 (2)

Omotayo O. O. 2005. Retirement in Sports Perspectives and Peculiarities. Conference Proceeding of the 46th ICHPER.S.D Anniversary World Congress Istanbul. Turkey. 602-605.

Omotayo O. T. 2013. *Consumerism and Advertisement: Analysis of The elderly Representation in Selected Advertisement.* International Journal of Multi-Disciplinary Studies and Sport Research (IJMSRE), 2, 523-532.

Omotayo O. T. 2016. Dynamics of Sports Retirement and Volunteering. A Paper Presented at the 3rd International Conference of the African Sports Management Association, ASMA, 16th – 18th June, 2016 at Nicon Luxury Hotel, Area 11, Garki – Abuja.p14

Omotayo O.T 2005. Global Ageing: The Challenges for Gerontological Social welfare. Paper presented at the 6th Pan African Social work. Conference Held at Kenyatta International Conference Center Nairobi. Kenya. 10th-14th April, 26p

Omotayo O.T 2012. Veneration of The elderly In *Things Fall Apart* and Ageism in Contemporary **African Society.** Paper Presented At ToyinFalola Annual Conference on Africa and the African Diaspora. 2nd-4th July 2012: 12.

Omotayo O.T 2014. The Economic Viability of Increasing Number of The elderly. *Journal of Inquiries in Sociological Studies.* 1 (1).154-161.

Omotayo O.T 2015a. Patterns of Human Rights Denial among some The elderly in Nigeria. In Yunusa. K.S, Fmakinwa. J.O and Fasiku G (eds). *Nationalism and Economic Justice in Nigeria*. 618-627

Omotayo O.T 2015b. Socio–economic Factors and Health Status as Determinants of Public Service Retirees' Life–satisfaction in the South–West, Nigeria. Ph.D Thesis University of Ibadan.

Onuoha C. 2016. 72 –years Old survives Machete Attack in His Farm by Three land Speculators. *Sunday Sun*. May,15:11

Osagie, O. 2010. WAEC Pensioners Protest in Benin. The Nation Newspaper. September, 17:7.

Osinusi, F. 2009. Still Working at 100. *Saturday Tribune*. September, 5:24.

Osinusi, F. 2009. Still Working at 100. *Tribune Newspaper* September 5:24.

Osula E. C 1993. The Nature and Importance of Research. *Introduction to Research Methodology*. Onotsha: Africana Rep Publisher.

Otti S. 2015. Retired Lagos Teachers Live on 2000 Monthly Pension. *Daily Sun Newspaper*. May, 25:17

Oyedele, A. 2010. First Female Professors Deploys Poor Treatment of the Elderly. *Punch Newspaper*. February, 15:11.

Oyerinde B. 2012. Lover Boy and His Mama. *Tell Magazine.* March 5:8

Palmer, M. 2009. 55 Percent of UK Citizens face Poverty in Retirement. *Punch Newspaper* September 9:43

Panzini RG andBandeira DR, 2005. Spiritual/religious coping scale (SRCOPE Scale): elaboration and construct validation. *Psicol Estud*..;10(3): 507-16.

Pargament KI, Koenig HG, Perez LM. 2000. The many methods of religious coping: development and initial validation of the RCOPE. Journal of Clinical Psychology. 56(4):519-43.

Parker, C., Barnes, S., McKee, K., Morgan, K., Torrington, J. and Tregenza, P., 2004. 'Quality of life and building design in residential and nursing homes for older people', *Ageing and Society,* 24(6): 941-962.

Patrick F, and Rychtarikova J. 2008. Living conditions for the elderly in the late twentieth century, in Gaymu J., Festy P., Poulain M. and Beets G. (eds.). *Future Elderly Living Conditions in Europe.* Paris: National Institutes of Demographic, 41–67.

Pocinlo R, Belo P, Antunes A, and Rodrigues R. 2016. Importance of Religiosity and Spirituality in Institutionalised Elderly. *ARC Journal of Public Health and Community Medicine* (1)1: 22-30

Popoola N. 2011. Retirement Saving Account: Assessing annuity, programmed withdrawal Options. *Punch Newspaper* April, 11:34.

Quadagno J. 2002. *Aging and the Life Course: An Introduction to Social Gerontology.* (Second edition). New York: Hill Higher Education.

Quadagno J. 2002. *Aging and the Life Course: An Introduction to Social Gerontology.* {Second edition}. New York: Hill Higher Education. Sciences 415{29]; 1-18.

Robinson, L., Clare, L. and Evans, K. 2005. Making sense of dementia and adjusting to loss: psychological reactions to a diagnosis of dementia in couples, *Ageing and Mental Health* 9(4): 337–47.

Salami S. O. 2010. *Retirement context and psychological factors as predictors of well-being among retired teachers*. Europe's Journal of Psychology 2/2010, *pp. 47-64www.ejop.org*

Salawuden. S. 2011. Senior Citizens get N 5,000 in Ekiti. *The Nation Newspaper.* October 26:10

Sandhu, J. and Arora, T. 2003. Institutionalized Elderly in Punjab – A Sociological Study of an Old Age Home'. Research and Development Journal, 9(3),24-28.

Saunders. C. 1980. Dying They Live: St Christopher Hospice 'Aging.' The Individual and Society. New York: St Martins Press.

Sibuh E. 2015. Exploring Effects of Institutional Care on the Life of Elderly: The Case of Mekedonia Humanitarian Association. A dissertation submitted to the Graduate School of Social Work, Addis Ababa University, Ethiopia http://etd.aau.edu.et/bitstream/123456789/8194/1/37.%20Eskedar%20Sibuh.pdf

Soriwel, F. 2011. Unrest Looms in Varsities as Unions Threaten Strike. *Punch Newspaper* July3:6.

Stevenson, O. 2008. Neglect as an aspect of the mistreatment of elderly people: reflections on the issues. *The Journal of Adult Protection* 10(1): 24–35.

Temilola O. M 2010. Poverty and wellbeing among the elderly in Iwo of southwest Nigeria. Ph.D Thesis in the Department of Sociology, University of Ibadan

Thane P. 1978. The muddled history of retiring at 60 and 65. *New Society,* 45(826):234-236.

The Punch 2011. Women 90 beats burglars with cane' August 25:44

The Punch 2015. Handling Pension Funds with Care. *The Punch*. May, 8:24

The Punch Newspaper 2010. 102 -Year Old Chinese Woman Begins PrimarySchool. April, 8:52

The Punch Newspaper, 2010. South African Dies Queuing for World Cup Tickets April, 16:60.1

Togonu- Bickersteth, F. 2014. *Ageing is not an emergency: Preparing for the new realities of ageing in Nigeria*. Ife, ObafemiAwolowo University Press Limited

Togonu-Bickersteth F. 2001. Growing old in Nigeria in the 21st Century: Academic and Policy Challenges. *Nigerian Journal of Ageing and Social Development.*1:2001

Togunu-Bickersteth F. 1987. Chronological definitions and expectations of old age among young adults in Nigeria. *Journal of Aging Studies,* 1(2);113-24.

Togunu-Bickersteth F. 1988. Perception of old age among Yoruba aged. *Journal of Comparative Family Studies.* 19(1):113-23.

Tomiak, M., Berthelot,J. M. Guimond,E, and Mustard,C. A. 2000. Factors associated with nursing-home entry for elders in Manitoba, Canada. *The journals of gerontology. Series A, Biological sciences and medical sciences* 55(5): M279–87.

Townsend, P. 1962. *The last refuge: A survey of residential institutions and homes for the aged in England and Wales*. London: Routledge and Kegan.

Townsend, P. 1965. The effects of family structure on the likelihood of admission to an institution in old age: the application of a general theory. In Shanas E. and Streib G.F. (eds.) *Social structure and the family: generational relations.* Englewood Cliffs, NJ: Prentice-Hall.

Udoh C. 2000. *Death and Dying Education.* Ibadan: Stiring –Horden Publisher.

uk/en/Healthcare/Longtermconditions/index.htm (accessed 5 December 2016).

United Nations 2015. *Department of Economic and Social Affairs, Population Division*. New York, NY: World Population Ageing Report.

United Nations 2016. www.un.org/sustainabledevelopment/development-agenda 2/10/2016{www.un.org/sustainabledevelopment/development-agenda) 2/10/2016

United Nations. 1985. The World Ageing Situation: Strategies and Policies. New York.

Vaarama M, Pieper R. and Sixsmith A. 2008. *Care related quality of life in old age*. New York: Springer science

Vanguard Newspaper 2015. Italian Wife Applied for Divorce. October 17:30

Victor, C. 2005. *The Social Context of Ageing: A Textbook of Gerontology*. Abingdon: Routledge.

Vitorino LM andVianna LA, 2012. Religious / spiritual coping in institutionalized elderly. *Acta Paul Enferm*; 25:13642 -

Wahab, E.O. 2005. Social and Economic Security of the Elderly a Study of The Ijebus of Southwestern Nigeria. Ph.D Thesis Department of Sociology, University of Ibadan

Walker J. 2007. *Introduction to Hospitality Management.* New Jersey: Library of Cataloguing in Publication.

Whitehouse, P.J., Gaines, A.D., Lindstron, H., and Graham, J.E. 2005. Anthropological contributions to the understanding of age related cognitive impairment. *Lancet Neurology*, 4, 320-326.

Wilensky. H, and LeBeaux . C 1958. Industrial Society and Social Welfare. New York: Free Press.

Wilson F.M. 2004. *What Work Means, Organizational Behaviour and Work: A Critical Introduction.* Oxford: Oxford.

Wolinsky, F. D., C. M. Callahan, J. F. Fitzgerald, and R. J. Johnson. 1992. The risk of nursing home placement and subsequent death among older adults. *Journal of gerontology* 47(4): S173–82.

Woo, J., S. C. Ho, A. L. Yu, and J. Lau. 2000. An estimate of long-term care needs and identification of risk factors for institutionalization among Hong Kong Chinese aged 0 years and over. *The journals of gerontology. Series A, Biological sciences and medical sciences* 55(2): M64–9.

World Health Organisation 2009. Definition of an older or elderly person. Available from: http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html (Accessed 02 March 2017).

World Health Organisation 2016. Long term care system. http://www.who.int/ageing/long-term-care/en/ (Accessed 07, November 2017)

World Health Organization 1999. *Ageing Exploding the Myths*. Geneva: World Health

Organization.

World Health Organization. 2002. Ageing Exploding the Myths. Geneva: World Health Organization.

Wu C-Y, Hu H-Y, Huang N, Fang Y-T, Chou Y-J, et al. 2014. Determinants of Long-Term Care Services among the Elderly: A Population-Based Study in Taiwan. *PLoS ONE* 9(2): e89213. doi:10.1371/journal.pone.0089213

Yehieli, M., Grey, M. A. andWerff, A. V. 2004. Care for Diverse Seniors*: A Health Provider's Pocket Guide to Working with Elderly Minority Immigrants and Refugee Patients* (online), Published 2004, Accessed 4th June 2013

APPENDIX I

DEPARTMENT OF ADULT EDUCATION

FACULTY OF EDUCATION

UNIVERSITY OF IBADAN, IBADAN

Dear respondent,

My name is ADEGBOLA, Gbeminiyi Mujaheed, a PhD student of the above mentioned department. I am conducting a research on the socio-cultural factors and institutional care facilities provision for the elderly in the southwest Nigeria. This questionnaire is intended to elicit responses on issues concerning the socio-cultural factors and institutional care facilities provision for the elderly. The data gathered with this questionnaire is intended for research use only and shall remain confidential. Please be confident to give honest responses.

Thank you.

Section A: To be completed by/for Residents

Name of Institution..... State:.....

DEMOGRAPHIC VARIABLES

1. Age: 60-64 ☐ 65-69 ☐ 70-74 ☐ 75-79 ☐ 80 ☐
2. Gender: Female ☐ Male ☐
3. Marital status: Single ☐ Married ☐ Cohabitation ☐ Separated ☐ Divorce ☐ Windowed ☐
4. Family size: Large ☐ Medium ☐ Small ☐
5. Family structure: Nuclear ☐ Extended ☐
6. Bereavement (recent loss of loved ones): Spouse ☐ Child(ren) ☐
7. Bareness: Adopted a child ☐ Without any child ☐
8. Education: Tertiary ☐ Secondary ☐ Primary ☐ Illiterate ☐
9. Social class: Upper class ☐ Lower class ☐ Middle class ☐
10. Living arrangement: Living with child ☐ Living with spouse ☐ Living with other ☐ Living alone ☐
11. Religion: Muslim ☐ Christian ☐ Others ☐
12. Housing condition: Well equipped ☐ Poor equipped ☐ Very poorly equipped ☐

13. House ownership: Owned a house ☐ Rented a house ☐ Others ☐

14. Income: 200,00 and above ☐ 150,000-199,000 ☐ 100,000-149,000 ☐

    50,000-99,000 ☐ below 50,000 ☐

15. Health: cognitive impairment Yes ☐ No ☐

16. Functional impairment: Yes ☐ No ☐

17. Inability to do self care (e.g. bath, clothe, use toilets): Yes ☐ No ☐

18. Inability to obtain instrumental care (e.g. do shopping): Yes ☐ No ☐

19. Any specific diseases: Yes (please specify)…… ☐ No ☐

20. Any long tern condition yes (please specify)…….. ☐ No ☐

21. Depression: Yes ☐ No ☐

22. Accident/fracture: Yes ☐ No ☐

SECTION B

DOMAINS	ITEMS	YES	NO
Disposition	Was the decision to use this facility yours?		
	Are you favourably disposed to this facility?		
	Did you ever imagine that you may use this facility?		
	Have you any regret for making this decision?		
	If you have another opportunity, would you have taken the same decision again?		
	Do you see anything wrong in the use of this facility?		
Accessibility	Was this facility easily accessible?		
	Was it easy to secure residence here?		
Legal Provision	Was there legal documentation involved before you secure residence?		
Cost	Is the cost of living in this facility cheap?		
	Do you get financial support for your upkeep?		
	Do you pay for this facility?		
Quality of Care	Do you have a personal room?		
	If no: do you issues with sharing a room?		
	Do you get adequate privacy?		
	If no: are there places you can use for private moment?		
	Do you think the care given to you is good?		
	Is it comfortable here?		
	Do you feel safe?		
	Do you think your life changed for better since you came here?		
	Do you think life has been worst since you came here?		
Staff resources	Do staff treat you with respect?		
	Do staff treat you gently, for instance, when helping you to sit-up?		
	Do staff consider the protection your modesty? For instance: Knock on the door before entering your room.		

	Are staff friendly with you?		
Care Process	Do the staff know you well enough?		
	Are your likes and dislikes known by the staff?		
	Are your wishes respected by the staff?		
	Do staff treat you with respect?		
	Do staff treat you gently, for instance, when helping you to sit-up?		
	Do staff consider the protection your modesty? For instance: Knock on the door before entering your room.		

APPENDIX II

FOCUS GROUP DISCUSSION GUIDE

Note: Ensure to use clear words or preferably, participants generated words to probe questions.

Disposition

Since when have you been thinking of using this facility?

Why did you decide to use this facility?

What are your major considerations before making the decision to use this facility?

What other options were available at the time of taking that decision?

Was the decision to use this facility solely yours or influenced by others?

When it was apparent that you were to be placed in Long term Care (LTC), were you indifferent? If no, why?

Were you favourably disposed to Institutional care for the elderly? If yes, why?

Was there any consideration about the societal view on the use of this facility?

Were there options available in lieu of institutional care?

If yes, please mention_____

Acceptability

What are the factors that are responsible for your usage of this facility?

Which factor do you consider most demanding?

Was there any other means of remediating the effect of this factor other than this facility?

Would you have cope with the factors had you not utilized this facility?

Cost:

How will you describe the cost of living in this facility?

Is it relatively affordable for an older person?

What kind of financial support do you get?

What is the average monthly expenditure incurred?

Utilisation of Institutional care facility

Since when have you been thinking of using this facility?

Why did you decide to use this facility?

What are your major considerations before making the decision to use this facility?

What other options were available at the time of taking that decision?

Was the decision to use this facility solely yours or influenced by others?

If you have another opportunity, would you have taken the same decision again?

Have you any regret for making this decision?

Determinants of Utilisation

What are the factors that are responsible for your usage of this facility?

Which factor do you consider most demanding?

Was there any other means of remediating the effect of this factor other than utilisation of this facility?

Would you have cope with the factors had you not utilized this facility?

Do you think an older person could decide to use this facility without any reason?

Demographic profile and Institutional care

Do you think growing older could make one want to use this facility? If yes, Why?

Old age come with challenges of self care, when the capacity for self care is challenge, do you think an older person may consider utilisation of this facility?

Do you think peradventure being a man or woman can make an older person use this facility? If yes, Why?

Do marital statuses have effect on utilisation of the elderly' institutional facility?

Family and Institutional care

What do you think the role of family are in the decision to use this facility?

Does the size and structure of family determine whether an older person will use this facility or not?

Can loss of family member or bereavement of an older person lead to usage of this facility?

Can bareness or lack of children lead an older person to this facility?

Is your family a source of support for utilisation of this facility?

Socioeconomic variables and Institutional care

Do you think social class can determine if an older person will use this facility?

Does level of education count in the utilisation of this facility?

Does religion have any influence?

Does your housing condition, whether your house was comfortable to live or not, influence your decision to use this facility?

Does house ownership, whether you own a house of your own or not, influence your decision to use this facility?

Does your previous living arrangement, whether you lived with or without your spouses, children or relative, influenced you utilisation of this facility?

Do you consider boredom or loneliness as factors that could make older person use this facility?

What effect has income in your decision use this facility?

Was your income enough to take care of your need before using this facility?

Do you finance this facility by yourself? If no, who by?

Health and Institutional care

Do you think health is the major reason why people use this facility?

Would the elderly without health challenges decide to use this facility?

What health condition do you consider burdensome to make an older person want to use this facility?

APPENDIX III

DEPARTMENT OF ADULT EDUCATION

FACULTY OF EDUCATION

UNIVERSITY OF IBADAN, IBADAN

Dear respondent,

My name is ADEGBOLA, Gbeminiyi Mujaheed, a PhD student of the above mentioned department. I am conducting a research on the socio-cultural factors and institutional care facilities provision for the elderly in the southwest Nigeria. This questionnaire is intended to elicit responses on issues concerning the socio-cultural factors and institutional care facilities provision for the elderly. The data gathered with this questionnaire is intended for research use only and shall remain confidential. Please be confident to give honest responses.

Thank you.

To be completed by care facility providers

1. When was this facility established? _____
2. What is the total number of beds in your facility ☐
3. Please indicate the number of residents who fall into each of the following categories

		Male	**Female**
a.	Long-stay/permanent	☐	☐
b.	Short-term respite	☐	☐
c.	Day care	☐	☐

4. Please indicate the number of residents in each of the following age groups. (For none, enter zero)

Age		**Number of long-stay residents**
a.	Less than 65 years	☐
b.	65-74	☐
c.	75-84	☐
d.	85-94	☐
e.	95+	☐

5. What is the average monthly charge for residents in your facility? _____

Staff resources

6. How many staff, in each of the following categories, are working your facility?

Category		Number of the whole-time equivalents
a.	Registered nurses (RN)	☐
b.	Care attendants	☐
c.	Health care assistants	☐
d.	Porters	☐
e.	Cleaners/housekeepers	☐
f.	Cooks	☐
g.	Administrators	☐
h.	Other (please specify)	☐
i.	Total	☐

Other (please specify):

Services and facilities

7. Are any of the following services available in your facility (please tick the appropriate box for each services)?

	Available Free of charge		Available privately for a fee		Not available	
Physiotherapist	☐	1a	☐	1b	☐	1c
Occupational therapist	☐	2a	☐	2b	☐	2c
Speech therapist	☐	3a	☐	3b	☐	3c
Social worker	☐	4a	☐	4b	☐	4c
Psychologist	☐	5a	☐	5b	☐	5c
Chiropodist	☐	6a	☐	6b	☐	6c
Dentist	☐	7a	☐	7b	☐	7c
Optician	☐	8a	☐	8b	☐	8c
Hairdresser	☐	9a	☐	9b	☐	9c

Others (please specify): _____

_____

Are any of the following communal facilities available for residents in your facility (please tick more than one box if appropriate).

Television ☐ a musical instruments

Newspapers ☐ b (e.g. piano) for general use ☐ f

Video/DVD ☐ c Shop (sale of general sundries ☐ g

Library/book
Lending ☐ d Public telephone ☐ h
Games ☐ e Tea/coffee making facilities ☐ i

8. Please indicate in which of the following places there is a call system installed in case of emergency (please tick more than one box if appropriate)?

Residents' rooms ☐ a
Bathrooms ☐ b
Wcs ☐ c
Corridors ☐ d
Other (please specify): ☐ e

PHYSICAL RESOURCES

9. How many of the following are in your facility?

Type of room number
Single rooms ☐
Double rooms ☐
Wards (defined as rooms with 3 or more people) ☐

10. (a) Was this facility purposely built as a long-stay residential facility?

Yes ☐ No ☐

11. (b)If no, what was the building previously used for (please take the appropriate box)?

Private residence ☐ a
Former hospital ☐ b
Hotel ☐ c
Guest house ☐ d
Other (please specify): _____e

12. (a)Is there a garden or outside recreational area attached

Yes ☐ No ☐

13. (b)If yes, can all residents access the garden or outside recreational area?

Yes ☐ No ☐

14. If the facility is multi-storey building, are there rooms or other resources for long-stay resident on upper floors?

Yes ☐ No ☐ Not Applicable ☐

15. If yes, is there a lift to upper floor?

Yes ☐ No ☐

16. Which of the following types of rooms are in your facility (please tick more than one box if appropriate)?

Separate dining room	☐	a
Sitting room(s) separate from residents dining room	☐	b
Sitting room(s) combined with residents dining room	☐	c
Sitting room(s) combined with reception area	☐	d
Reception area separate from residents' sitting room(s)	☐	e
Private room/space for entertaining visitors	☐	f
Child-friendly area (e.g. with a toy box) for children while visiting relatives	☐	g
Separate activities room	☐	h
Other (please specify)	☐	i

17. Please provide information about the bathroom facilities indicating the number of each of the following:

Bathroom facilities number		
Ensuite rooms	☐	a
Wcs with fixed grab rails	☐	b
Wcs that are separate from bathrooms and showers	☐	c
Special baths	☐	d
Wheelchair accessible showers	☐	e
Bath aids and appliances	☐	f

Thank you for your time.

APPENDIX IV

In-depth Interview Schedule for Staff

How many years have you spent with this institution? _____

Socio-cultural disposition

What would you say about the disposition of our contemporary society to institutional care for the elderly?

Acceptability

Do you think the elderly that use your facility willingly accept your care service without resentment?

Capacity

Does your facility have the required capacity to care of the bio-psychosocial need of the elderly using your facility?

Level of Utilisation

In your own opinion, do you think your facility is being utilized to the maximum?

Legal Provision

What are the legal requirements involved in the provision of institutional care for the elderly?

Cost

How can describe the average cost of care for the elderly in your facility?

APPENDIX V

UNIVERSITY OF IBADAN
FACULTY OF EDUCATION
DEPARTMENT OF ADULT EDUCATION
Informed Consent Form

IRB Research approval number:_____

This approval will lapse on:_____

Title of the research: Institutional care provisions for the elderly in South West Nigeria.

Name and affiliation of researcher of applicant: Gbeminiyi Mujaheed ADEGBOLA of the Department of Adult Education, University of Ibadan, Ibadan.

Purpose of Research: The purpose of this research is to investigate the provisions of institutional care facilities for the elderly in the south west Nigeria.

Procedure of the Research: Visit shall be paid to all the institutional care facilities for the elderly in southwest Nigeria. Questionnaire shall be administered to the elderly who are residents or outpatients in the facilities. Participants shall be required to fill the questionnaire. Trained Research Assistants shall be available to assist the participants in the course of completing the questionnaire. Focus Group Discussions shall be conducted with participants to elicit further responses that may not have been addressed by the questionnaire. Participants are expected to be in a group of six and participate freely in the discussion group. Questionnaire and interviews shall also be conducted for the professional care providers in each facility. The caregivers (relative(s) of the older person(s) who is responsible for their care) shall also be interviewed through a telephone contact. The caregivers would be contacted on the telephone and be briefed on the purpose of the research after which a convenient time for telephone interview would be fixed and conducted accordingly.

Expected duration of research and of participant(s)' involvement: Participants are not expected to be involved beyond a day or two at most.

Risk: No risk is attached to participants involved in this study.

Cost to the participants: This study is of no cost to the participant.

Benefits: This study would help address issues that would enhance effective service delivery for the elderly using institutional care facilities presently or in the future.

Confidentiality: No name or traceable record will be attached to all instruments used to gather data for this study. All information gathered would be kept private and strictly used for the purpose of research and nothing more.

Voluntariness: Your participation in this research is entirely voluntary and you may choose to withdraw at any point.

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to ,ake an informed decision.

Date: _____ Signature: _____

Name: _____

Statement of person giving consent:

I have read the description of the research or have had it translated into language I understand. I have also discussed with my care provider to my satisfaction. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

Date: _____ Signature: _____

Name: _____

Detailed contact information:

This research has been approved by the Ethics Committee of the University of Ibadan and the Chairman of this committee can be contacted at the Department of Sociology, Faculty of the Social Sciences, University of Ibadan. Email: sayjegede@yahoo.com. In addition if you have any question, you can contact the principal investigator, Gbeminiyi Mujaheed ADEGBOLA, Department of Adult Education, 08163881377. Email: gbeminiyiadegbola@gmail.com.

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

APPENDIX VI

NOTICE OF ETHICAL APPROVAL

UNIVERSITY OF IBADAN

Chairman: Prof. A.S. Jegede, B.Sc, M.Sc. (Ife), MHSc (Toronto), Ph.D (Ibadan)
Tel: +234-8055282418
Email: sayjegede@yahoo.com
sayjegede@gmail.com
as.jegede@mail.ui.edu.ng

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Institutional Care Provisions for Older Persons in South West Africa

UI/Social Sciences Ethics committee assigned number: UI/SSHREC/2018/00015

Name of Principal Investigator: **Gbeminiyi M. ADEGBOLA**
Address of Principal Investigator: Adult Education
Faculty of Education
University of Ibadan
Date of receipt of valid application: 13/04/2018
Date of meeting when final determination on ethical approval was made: 24/07/2018

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the SSHREC Committee.

The approval dates from **24/07/2017 to 23/07/2019.** If there is delay in starting the research, please inform the SSHRE Committee so that dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the SSHE Committee assigned number and duration of SSHE Committee approval of the study. It is expected that you submit your annual request for the project renewal to the SSHE Committee early in order to obtain renewal of your approval to avoid disruption of your research.

Note: the National code for research ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the SSHEC. No changes are permitted in the research without prior approval by the SSHEC except in circumstances outlined in the Code. The SSHE reserves the right to conduct compliance visit to your research site without previous notification.

Prof. A.S. Jegede

APPENDIX VII

GUIDELINE ON

BASIC MINIMUM REQUIREMENTS

FOR

THE PROVISION OF RESIDENTIAL CARE FACILITIES

FOR THE ELDERLY IN SOUTH WEST NIGERIA

1. Preamble

This policy guideline proposes the standard operating procedure for the establishment and operation of residential care facilities for the elderly. This is due to the observations of the research on institutional care provisions for the elderly in southwest Nigeria. The vacuum observed in the provisions of residential care facilities, the irregularities and the inconsistencies in the processes and quality of care across available facilities called for uniform standard procedure in the establishment and operation of institutional care facilities in the study area.

2. General

This document provides guide for the establishment of institutional care facilities for operators and the staff of the residential care facilities. The guide is designed as a framework for basic minimum requirements for the provisions of institutional care facilities.

3. Supervision

The Government Ministry (Federal Ministry of Women Affairs and Social Development) responsible for the care and management of the elderly, must be empowered by law to provide a supervisory role towards achieving the enforcement of all regulations regarding the care and management of the elderly. The supervision should bother on:

- The essence of informal care by family members and relative as enshrined in the social development policy of 1989 that places more emphasis on the role of the traditional family system in ensuring adequate care for the older family members. The supervision should underscore the significant roles of relatives, friends and family member in shouldering the responsibility of care and providing support for the elderly who are residents in the various care facilities. This is imperative to avoid in

part, abandonment and abscond from responsibilities, and ensure periodic monitoring of the welfare of their wards.

- Optimal wellbeing of residents with specific attention on the needs of individuals. Emphasis should be on the socio-cultural needs of the client and the provision of social and physical environment favourable to the shared values of the residents.
- Periodic assessment of the quality and processes of care to ensure efficient and effective care service delivery for the residents of the facilities.

4. Establishment and Registration

- All operators must apply to the supervisory ministry of the government for approval and license to operate;
- Operators must have relevant trainings in care and management of the elderly in health and social work;
- Operators must present evidence of proof of ownership or lease agreement of the proposed facility to be used;
- Operators must provide security clearance from necessary authorities;
- The proposed facility must in addition to providing all necessary requirements stipulated by the Federal Ministry of Women Affairs and Social Development for Adult Day Care centers, comply with the minimum standard requirements for adult residents thus:

    a. The facility must have a perimeter fencing and secluded from unwanted intruders;
    b. There should be one entry/exit door to prevent wandering of residents as this is a common peculiarity with the elderly. Where entry/exit is more than one, door watch system should be fixed at all entry/exit;
    c. A garden for outdoor activities (such as gardening) must be available within the facility;
    d. Fire safety measures and equipment must be fixed in the facility;
    e. All floor in the facility must be wheel complaint;
    f. Common room with comfortable furniture must be available in the facility;
    g. Sitting room/Common room must be separated from the dining room;

h. Recreation room where indoor activities and games are available should be provided in the facility;
i. The facility must be devoid of stairs, where the operator wishes to use a storey building, ambulatory facilities and lift must be available;
j. Fixed grab rails must be available around the corridors, passages, and all the rooms in the facility, particularly, the bathroom and toilets;
k. Non-slippery materials must be used for the floor of the facility;
l. The acceptable ratio of residents to toilet must not exceed 3:1
m. The bathroom doors should have locks that could also be accessible from the outside in case of emergency;
n. Bedrooms must be spacious enough and furnished with bedside tables, lamps wardrobe, dresser and waste disposers.
o. No bedroom must access the other, and residents must be separated by gender unless when special arrangements are requested;
p. The bedroom must not accommodate more than two residents.
q. Standard single bed at least, with two sheets, pillow and pillow case to be replaced periodically every other day must be provided;
r. The acceptable ratio of residents to rooms must not exceed 3:1. This is acceptable only where large rooms are used;
s. Call-bell facilities must be available in all rooms, bathrooms, toilets and corridors in case of emergency.

- Operators must Swear an oath of secrecy and confidentiality of all personal information of residents
- Operators must provide a proposal to comprise the mission statement, vision, objectives and plan to cater for the social, psychological, spiritual and medical needs of the residents. The proposed plan must include the routine of activities to carried-out in the facilities.
- After due documentation with the ministry, the number of residents to be admitted in each facility must be subject to the approval of the ministry based on the assessment of the facility.
- Operators must also present evidence of insurance which would cover the residents for accidents or mishap or any other incidents that may be life threatening in the facility.

5. Personnel and Staff

Operators must ensure that

- All staff, except for service staff such as cleaners and cooks, working in the facility should have specialised training in gerontology;
- Staff primarily responsible for the care of the residents must have training in any of the following with specific bias for geriatrics;
    - Social work programme
    - Nursing
    - Health Assistant/ Technician programme
    - Paramedics Technician programme
- All staff working in the facilities must have basic training in first aid cardio-pulmonary resuscitation;
- Staff are made to swear oath of confidentiality to keep discreet all information of all residents;
- The acceptable ration of residents to staff carers (staff that attend to psycho-social and medical care of residents) to residents must not exceed 4:1;
- A staff Nurse, Health Technician/Assistant and Social worker must always be on every shift duty;
- At least a medical officer, preferably a geriatrics specialist, must be on call at all times;
- All staff must present their licences to practice prior to their employment.