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Perceptions of Quality of Eldercare among the Elderly and their Caregivers in Nigeria

By

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Degree to be awarded: MPH

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Perceptions of Quality of Eldercare among the Elderly and their Caregivers in Nigeria

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Bachelor of Arts, English

Hood College

2013

Thesis Committee Chair: Dr. Deborah McFarland, MPH, PhD

An abstract of

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Abstract

Background: As the global population ages, sub-Saharan Africa remains one of the youngest regions in the world. Much research on the elderly takes place in countries where the demographic transition has already begun, with little qualitative research on elderly from low- and middle-income countries.

Objective: To understand how the perception of quality of eldercare differs among the elderly, their caregivers, and change-makers in Nigeria. In the Nigerian context, health care options for the elderly include private and public health care, native medicines, and care provided by family members.

Methods: Interviews and focus group discussions with elderly and caregiver participants were conducted in urban and rural sites in three states during the summer of 2016. Key informant (change-maker) interviews were conducted in each community. Data were analyzed using a thematic analysis approach.

Results: Primary health care is perceived as ineffective and inefficient due to high referral rates to higher-level institutions and inadequate staffing and equipment. Secondary- and tertiary-level health care are perceived as inaccessible because of high cost. Universally, private health care is seen as better-quality than public health care. Many elderly participants supplemented or exclusively medicated with native medicines (herbal concoctions and teas). Care provided by families was highly patient-centered, taking into account the elderly person's wants and desires. Despite this, reports of abuse and neglect are pervasive in the data.

Discussion: The dominant perception of eldercare in Nigeria is one of 'care reciprocation'. In this system, parents invest in their children and later, children are expected to provide good 'return on investment' by caring for parents in their old age. The breakdown of this system results in neglect and abuse of elderly persons and blame is placed squarely on the youth.

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Introduction

As much of the world enters the last stages of the demographic transition, population aging is becoming ever more apparent. Population aging occurs when the median age of a population increases over time. For example, the median age of the world population in 2000 was 26.6 years. By 2050, median age will be 37.3 years, and by 2100 median age will be 45.6 years (Lutz, Sanderson, & Scherbov, 2008). Many of the world's health and welfare systems are unprepared for the growth in aged populations. Older people have greater healthcare needs and some have forecasted an "apocalyptic" rise in health care costs (Evans, McGrail, Morgan, Barer, & Hertzman, 2001). Others believe that population aging is too gradual a process to be a major driver of increasing health care costs (Reinhardt, 2003). While change at the health system level is uncertain, population aging will have tangible effects at the household level.

Perhaps the most significant impact of population aging will be an increase in dependency ratios, meaning that every working person will support more economic dependents. Conceptually, population aging appears as a bulge in a population pyramid. As the population ages, this bulge moves upward and the pyramid becomes more slender at the base. This slender base indicates that there are fewer young people to support each older adult (or child). Family finances may become tighter as there are fewer earners to support an increasingly elderly population. In higher-income countries, the impacts of population aging will be less severe than impacts in low- and middle-income countries. Public pension programs and social welfare will mitigate some of the financial effects. However, the impact of population aging in low- and middle-income counties (LMICs) is less well-known.

Generalizing trends in eldercare in LMICs is difficult as all have differing levels of financial and institutional support for the elderly. There is a dearth of research on elder care in LMICs and I hope to add to this body of research by performing an exploratory analysis of eldercare and caregiving in Nigeria, focusing specifically on perceptions of quality of elder care.

Problem

Population aging is occurring everywhere with the exception of sub-Saharan Africa (He, Goodkind, & Kowal, 2016). Most of this region is experiencing a youth bulge, which refers to a population pyramid that is skewed toward younger ages. Population aging may not yet be a research priority in sub-Saharan Africa, since the number of people over age 65 is relatively small. But while population aging has yet to occur, fertility rates have declined across Africa (J. C. Caldwell, Orubuloye, & Caldwell, 1992). This decline is happening slowly, but it is an indication that population aging will eventually occur in sub-Saharan Africa, given that current trends continue. It is unlikely that the total fertility rate in sub-Saharan Africa will be at replacement level in this century, so population aging may not occur in the foreseeable future. Despite this, the number of elderly people in Africa is expected to quadruple by 2050 (He et al., 2016). Many governments and health care systems will see an increasing number of elderly patients with chronic diseases and co-morbidities that require cohesive disease management by health practitioners. Families may have to allocate more of their household income to care for an elderly relative. Preparing for these changes ahead of time at a national level may mitigate potential negative effects.

There is a need to explore perceptions regarding quality of eldercare in Nigeria to inform future interventions at the national and/or community level. Interventions would be more effectively implemented at these levels because the government of Nigeria is centralized and individual states have few opportunities to create policies or programs. The projected increase in the

elderly population of sub-Saharan Africa justifies this research, especially its unique standing as the only region yet to experience the beginnings of population aging. In some regions, population aging began thirty years ago and this research will give important insight into a region at the initiation of the demographic transition. In addition, data on aging in sub-Saharan Africa is sparse when compared to research from other parts of the globe. I hope to add to this small body of research by performing an exploratory analysis on the perceptions of the elderly and their caregivers on the quality of eldercare.

Purpose and Research Questions

The purpose of this research was to understand the experiences of the elderly and their caregivers in Nigeria. I decided to narrow in on perceptions of quality of care from formal and informal health providers because participants spoke most completely about this topic. Including both the formal and informal health care system expanded the breadth of the research question, especially considering that the majority of caregiving takes place within the home. Because there are diverse health care options in Nigeria, I was curious to see how perceptions of quality of care differed between types of care. The research was conducted with three groups: the elderly, caregivers, and change-makers. The change-maker group included health professionals, village leadership, and social servants at various levels of government and influence. In sum, the research question is:

> How does the perception of quality of eldercare differ between the elderly, their caregivers, and change-makers?

Quality of care will be defined using the WHO's Six Dimensions of Quality framework, which will be discussed in the Methods section of this paper. With this question, I attempt to

capture diverse views on the quality of the health care system in Nigeria to provide a more holistic understanding than previous research has described.

Definition of Terms

In a discussion of population aging, it is important to first define who is considered 'elderly'. Universally, old age is described in physical terms (increasing frailty), life events (retirement), or social roles (being a grandparent) (Lloyd-Sherlock, 2000). But definitions of old age can be somewhat problematic. In some cultures, old age may span as long as three decades, so researchers typically designate between "young-old" and "old-old". Describing the elderly in these terms is easier than using chronological age, but is more subjective. Depending on average life expectancy in a given country, the ages of those considered young-old and old-old may vary greatly. For example, a person who is 50 years old may be described as young old in some contexts and middle-aged in others. Additionally, only a small proportion of the population may be old-old in less-developed countries. For the purposes of the literature review, I will use standard definitions from the United Nations; young-old will be considered 60 and above and old-old, 80 and above (United Nations, 2015). 'Old' as an adjective to describe a person may have negative connotations, so when applicable, I will use the terms third age (young-old) and fourth age (old-old) (Baltes & Smith, 2003).

When discussing caregivers or caregiving, I am referring to caregivers of the elderly. More detail on the definition of caregiving in the context of this research is provided in the Methods section. Even though the WHO's Six Dimensions of Care are providing a flexible structure with which to analyze the data, quality of care is highly subjective. For example, a caregiver can provide good care one day, and bad care the next. Another difficulty in discussing quality of care is that it is multifaceted. An elderly person may have enough to eat, but may not be able to move around the house or go outside. This study does not aim to measure quality of care, rather it aims to get a

general sense of which element of quality applies in each care setting. Formal health care is defined as care that takes place within a health facility, be it a doctor's office, clinic, or hospital. Home health services provided by trained nurses or nurses' aides is also considered formal care. Essentially, formal care occurs when money is exchanged with a qualified practitioner for care or treatment. Informal care occurs when family or friends provide care. This definition also applies to native doctors who prescribe herbs and teas to treat ailments.

Significance

Population aging is occurring worldwide, and although sub-Saharan Africa has yet to experience the final stages of the demographic transition, it is inevitable that this transition will occur in the future. By researching aging in a region where it is often overlooked, we can create a more complete picture of how population aging (or lack of) is affecting provision of care in all regions of the world, not just the global north.

The findings of this research may be used to generate questions for further research. This project is broad in nature and all the topics presented here would benefit from further exploration, especially research on federal policies regarding eldercare. Research on polices would be likely to have the most impact, not only because federal policies affect many people, but because it may initiate more thinking about the needs of the elderly at the national level. In a country of 180 million people, only five million are above age 65 (He et al., 2016; National Population Comission (NPC) [Nigeria] and ICF International, 2014). After taking into account trends in need and disease burden, a policy intervention could have major implications for the elderly and may not be overly-expensive, given the number of people above 65 (federal retirement age in Nigeria) is so small. It is our hope that this research can serve as a small contribution to the field of global aging and will add to an increasing body of literature on aging in LMICs.

Literature Review

Introduction

The structure of this literature review will move from a broad discussion of global aging and will narrow in focus to aging in sub-Saharan Africa, and then to aging in Nigeria. I will also discuss the demographic transition, the health care system in Nigeria, and family caregiving, since these areas are related to my research questions. Finally, I will present my conceptual framework for the study and discuss strengths and limitations of the literature reviewed.

The literature reviewed was from peer-reviewed journals as well as non-peer reviewed sources such as reports, bulletins, and online newspaper articles. All materials were in English. While the majority of scholarly research in Nigeria is written in English, the exclusion of non-English sources may have limited exposure to ethnically diverse literature. No articles were excluded because of publication date. Some of the processes described here are demographic changes that occur over decades and centuries. By including literature from the eighties and nineties, changes in demographic theory can be seen over time. Both quantitative and qualitative data were reviewed to support the formative goals of the research design. This project aimed to explore aging in Nigeria from a holistic viewpoint. This review will reflect that goal, while going into more detail on topics necessary to answer the research question.

Global Aging

As life expectancies increase and fertility rates decline, the proportion of people aged 65 and older worldwide is expected to double by 2050, whereas overall population growth is projected to be slower, increasing 34% by 2050 (He et al., 2016). As we near mid-century, the elderly will constitute an increasing portion of the total global population. Almost two-thirds of people aged 85 and older

currently live in high-income income countries, but by 2050, only one-fifth of older adults will reside in high-income countries (He et al., 2016). Increases in the elderly population are anticipated on a global scale, but there is significant variation in the rate of population aging. By 2050, Asia is expected to have the highest proportion of elderly in the population, with South Korea's population aging at the fastest rate (Schoeni & Ofstedal, 2010). Africa will continue to have a large proportion of young people, but the number of elderly people is expected to quadruple by 2050 (He et al., 2016).

As longevity increases, scholars posit three implications for populations aging effects on morbidity in older adults: an expansion of morbidity, an equilibrium in prevalence and severity of morbidity, and a compression of morbidity (Cambois, Robine, & Hayward, 2001; Crimmins, 1990; Nusselder, 2003). An expansion of morbidity means that older people will experience morbidities at younger ages, essentially increasing the years that people are sick prior to death. It is difficult to draw conclusions about population aging because the elderly are a heterogeneous demographic, but four main elements of population aging have emerged. These are:

1. An increase in survival rates among those who are sick (expansion of morbidity),
2. The emergence of chronic disease among the oldest-old, rather than young old, as a main contributor to mortality (equilibrium of morbidity),
3. Improved health behaviors among the elderly (compression of morbidity), and
4. The development of older and frailer populations (expansion of morbidity) (Robine & Michel, 2004).

These factors combine to make population aging and its consequences for individuals, households, communities, and health systems all the more complex.

Some of the most significant increases in longevity are the result of technological advances in medicine and pharmaceuticals, better maternal and child nutrition, and improved access to education and health care, among others. Disability is now pushed back toward end-of-life as people live longer and healthier lives (Fries, 1980). But these findings are specific only to countries in the later stages of the demographic transition. Most less and least developed countries have experienced neither a compression in morbidity nor increased longevity because of healthier lifestyles or increased access to technologically-advanced medicine (Lloyd-Sherlock, 2000). Many elderly people lack the resources to live disability-free. Progress has been slow to address disability among the elderly and some cite the viewpoint that providing resources for the elderly shrinks resources for the young as a contributor to sluggish interest (Kalache, Aboderin, & Hoskins, 2002). Because of the prioritization of spending on other demographics, many older people in less developed countries are without financial support as scarce public funds are diverted elsewhere or never allocated.

One emerging pattern of population aging is the 'feminization of old age' (Ginn & Arber, 1991). The majority of those in the fourth age (80+) are women. This discrepancy is due partly to differences in genetic makeup, but is also a result of higher mortality of men in early years due to violent deaths, accidents, or chronic disease later in life. It is important to note that this trend is not observed in all countries, especially those in which women have been socioeconomically disadvantaged. India, for example, had more men above 60 than women in 1990 (Lloyd-Sherlock, 2000), although this is atypical of demographic trends.

One of the most conclusive pieces of evidence is the role of education on health. While it is widely accepted that more education corresponds with better health (Ross & Wu, 1995), this trend is especially pronounced in older populations who came of age when education was a privilege almost

exclusively for the wealthy. In many low- and middle-income countries (LMICs), older people are more likely to be illiterate, especially older women. Low levels of education have been shown to be a strong risk factor for dementia (Borenstein, Copenhaver, & Mortimer, 2006). Some point out that the link between dementia and education level may not be direct, with social class acting as an effect modifier (Scazufca et al., 2008). Those in higher social classes are more likely to be educated and less likely to have dementia later in life. Despite this, the reported prevalence of dementia and Alzheimer's disease is far lower in less developed countries. Prevalence of dementia in the Yoruba of Nigeria was 2.3%, while prevalence in an African-American community in Indianapolis was 8.2% (Hendrie et al., 2001). Some attribute the low incidence of dementia among the Yoruba to nutritional factors. A low-calorie and low-fat diet consisting of mostly grains, yam, vegetables, and fish may contribute to the lower incidence of dementia and Alzheimer's disease among the Yoruba (Hall et al., 2006).

The Demographic Transition

The demographic transition theory posits that industrializing societies move from high fertility and high mortality to low fertility and low mortality (Kirk, 1996). The transition first began in the 1800s in Europe, but has since spread to all parts of the world and is projected by some to be complete by 2100 (R. Lee, 2003), although some are uncertain whether Africa will ever enter the final stage of the demographic transition (Lloyd-Sherlock, 2000). To put the demographic transition in context: compared to the early 1800s, there will be 50 times as many elderly, but only five times as many children in 2100 (R. Lee, 2003). Population aging is occurring more slowly in Africa, which is projected to remain young in coming decades due to continued high fertility rates. Even by 2050, it is expected that a majority of countries in Africa will still have total fertility rates well above replacement level (He et al., 2016).

Global population aging is partly attributable to falling fertility rates. Excepting sub-Saharan Africa, all regions of the world are experiencing fertility rates at or below replacement level (He et al., 2016). This has important implications for the dependency ratio, defined as the number of individuals younger than 15 or older than 64 divided by the number of individuals between those ages. In essence, the dependency ratio compares the number of economically active persons to the number of economically dependent persons. In the short term, low fertility rates result in a low dependency ratio because 'workers' do not have children as dependents. In the long term, low fertility rates lead to an increase in the dependency ratio as these same workers support the aged (Kapteyn, 2010).

Macroeconomic implications of increasing dependency ratios are far-reaching. As the dependency ratio increases, there will be fewer workers to support each child or elderly person. Governments and 'worker' generations will need more resources at their disposal to care for an increasingly older population. Workers may need to save more over the course of their lives to offset the cost of elderly dependents. Some may delay retirement (Lee & Mason, 2010). Families and individuals will need to plan further in advance to be more financially secure later in life.

Aging in Sub-Saharan Africa

In regards to the elderly in sub-Saharan Africa, two primary assumptions are at work. The first asserts that family networks are more extended and that close-knit families work as a team to care for elders. The second assumption is that chronic disease is not a top priority, because infectious disease remains a greater contributor to mortality (Young, Critchley, Johnstone, & Unwin, 2009). However, cultural and epidemiologic shifts are taking place that may result in the breakdown of both these assumptions. As the demographic transition takes place, chronic diseases are accounting for an ever greater proportion of mortality. While up to 69% of mortality on the

continent is still due to infectious disease, chronic disease is the main cause of mortality for older people, similar to worldwide trends (Aikins et al., 2010). And as younger generations move to urban areas to seek economic opportunities, family ties may suffer. This leaves the elderly particularly vulnerable. While there is no specific data on the age demographics in rural and urban areas, a study measuring hypertension in Enugu State found that 41% of their rural study population was aged 55-64, while only 25% of their semi-urban study population fell within these ages. This study did not recruit those over 64 years. The authors attribute these differences in age to urban-rural migration (Ulasi, Ijoma, & Onodugo, 2010).

Urban-rural migration is an integral part of understanding the relationship between the older and younger generations in Nigeria. Migration from rural to urban areas began in the 1970s after an oil boom increased government revenue. Much of this revenue was invested in urban areas and rural-dwellers were drawn to the city by jobs in the construction and service sectors (De Brauw, Mueller, & Lee, 2014). This migration has continued to present day and contributes to lower numbers of young people in rural areas proportional to their numbers in the general population. It's important to acknowledge that this migration moves both ways, although for different reasons. Migration to rural areas occurs on a much smaller scale, often because of inability to find work in town, high cost of living in urban centers, and retirement (Adewale, 2005). In this push and pull mechanism, younger people are more likely to move to the city than other groups, and older people are more likely to move to rural areas.

The decision to migrate is a household decision rather than an individual one. Many households justify a young person's migration to the city as a way to increase household income. This would explain remittance behavior of those who migrate to urban areas (Taylor, Rozelle, & De Brauw, 2003). Depending on family size and role of the migratory individual in the household,

opportunity cost of their departure might be low. In some cases, a family member's departure from the household may mean there are more resources for the family, given that money is remitted (De Brauw et al., 2014). Data on urban-rural migration in sub-Saharan Africa is sparse, but younger generations leaving for urban areas undoubtedly have an impact on older generations who remain in rural areas.

The Formal Health Care System

Structure

Nigeria's public healthcare system began to take shape in the post-colonial period. As more and more hospitals were built, fueled in part by the oil boom of the 1970's, drugs and medical equipment became problematic to obtain. Nigeria's economy had relied heavily on imports to offset these growing costs, and the public health care system began charging fees for service. These fees, combined with equipment and staff shortages, were the impetus for the emergence of private and missionary health facilities (Alubo, 2001).

As private health care became more common, facilities began to lower their prices to compete with other local providers. A group of for-profit private facility owners were concerned that these arbitrarily low prices were affecting quality of care. In 1992, this group devised a fee schedule to be used by all licensed private facilities. Between 1992 and 1995, this fee schedule changed several times, increasing costs 200% over the period (Ogunbekun, Ogunbekun, & Orobaton, 1999).

There are two types of care in the formal Nigerian health care system: public and private. At the primary level, only public healthcare is available (Asuzu, 2004). At the secondary and tertiary levels, both public and private options are available. Public facilities include federal medical centers, teaching hospitals, and general hospitals (Akanji, Ogunniyi, & Baiyewu, 2002). Private facilities

include specialist hospitals, maternity homes, pharmacists (chemists), and clinics. Herbalists who specialize in native medicines are also part of the private health system, but in an informal capacity.

Community health workers typically run primary healthcare (PHC) facilities and have 1 to 2 years of training, somewhat equivalent to the training of a paramedic in the U.S. (Akanji et al., 2002). The goal of these facilities is to provide inexpensive drugs and services to as many people as possible. This goal was advanced by the adoption of The Bamako Initiative, which is a fund that provides certain generic drugs at a highly subsidized rate. Many PHC facilities quickly run out of these essential drugs and poor prescribing practices have led to inappropriate use of medication. (Uzochukwu, Onwujekwe, & Akpala, 2002).

The majority of secondary and tertiary private facilities are for-profit and single-owner. While public primary care exists in areas with varying degrees of urbanicity or rurality, private facilities are concentrated in urban centers. Fees for service in private facilities have become so high, that private health care is out of reach for most. To offset declining numbers of patients, many private facilities are sponsored by public organizations and private corporations (Alubo, 2001).

Quality of Care

The quality of health services varies widely across the health system. Starting at the primary level, services are underutilized because facilities rarely have equipment and staff to meet the needs of communities. An audit of PHC facilities in Enugu State found that the majority did not provide the services required, were poorly maintained, did not have adequate staff, and had no budget (Chukwuani et al., 2006). For this reason, many bypass primary care entirely and go directly to public or private hospitals. Patient satisfaction is higher in private facilities. These facilities have shorter waiting times, shorter travel times, and are reported to treat patients more respectfully than public

facilities. In regions where many private hospitals compete for business, high-quality customer service is one of the main attractors of private facility care (Adesanya et al., 2012).

There is mixed evidence on how Nigerians choose where they go for healthcare. One study found that distance to the health facility was the primary determinant for choice of health care provider. In this same study older people were more likely to visit public and private hospitals rather than clinics, because hospitals can provide more comprehensive specialist's care (Amaghionyeodiwe, 2008). Another study conducted in Kogi State found that both distance and total cost of care were primary determinants of health provider choice (Awoyemi, Obayelu, & Opaluwa, 2011). Regardless of individual study findings, the literature is in agreement that rural dwellers have the least access to healthcare.

The Role of Elders

The elderly are an integral part of the social fabric of most communities. Not only do they serve as counselors for younger generations, but in countries hard hit by HIV/AIDS, many orphaned children are cared for by their grandparents. The elderly also represent a significant portion of the labor force, especially for smallholder farms, which constitute a large portion of the food supply. As younger generations leave rural areas, older generations stay behind and farm the land. Because the elderly may be sustaining more than just themselves, their decreases in physical or cognitive functioning may have repercussions on the health of the rest of the family (Aboderin & Beard, 2015).

Traditionally, elders are the nexus of family structures and are highly respected. This respect is not predicated by numerical age, but rather the maturity and wisdom that comes with raising multiple generations. Elders without children are rare in sub-Saharan Africa, but in these cases, they may be more vulnerable than elders with children. In fact, elderly persons who are widowed and

without children are more likely to experience chronic poverty, which among older women may be exacerbated by a lack of property or ownership rights (Heslop & Gorman, 2002). In sub-Saharan Africa, women tend to marry young to older men and as a result, husbands typically pass away first. Widows do not usually remarry, so having children to provide a source of income is essential. The majority of elderly men are married and some may practice polygamy (Oppong, 2006). With fertility rates in Nigeria at 5.5 births per woman, more wives typically means more children in the household, serving as social and financial 'insurance' for an elder as they enter third and fourth age (National Population Comission (NPC) [Nigeria] and ICF International, 2014).

Health Status of Elderly Nigerians

Prevalence of disability in Nigeria is unknown as estimates vary widely, although major contributors of older-adult disability are depression and chronic disease. Although prevalence of Alzheimer's and dementia has been reported to a far lesser extent than more developed countries (Hendrie et al., 2001), 12-month prevalence estimates for depression among older Yoruba-speaking Nigerians is 7.1% (Gureje, Kola, & Afolabi, 2007).

One of the most significant barriers to long life in sub-Saharan Africa is poverty. Over 70% of Nigerians live on less than $1.25 a day (Central Bank of Nigeria, 2011) and there is no national social welfare program to ease the financial burden of care (Ojagbemi, Bello, Luo, & Gureje, 2016). Because health care options are limited by socioeconomic status (SES) (Uwakwe et al., 2009), the longevity and quality-of-life of an older person will be dependent in part on the family's financial resources. As the epidemiologic transition occurs, there has been some pushback against the assertion that those of lower SES have inherently worse health outcomes. Those of high SES may be at greater risk for different kinds of morbidity and mortality. A study on the elderly in Costa Rica found that those in the highest SES gradient were at increased risk for hypertension and obesity than

those at the lowest. Those in the lowest SES gradient had an increased risk of cognitive disability, physical frailty, and depression (Rosero-Bixby & Dow, 2009). While both ends of the SES gradient are associated with risk factors, those at higher SES will have more health care options at their disposal than those of lower SES, especially in Nigeria where no public welfare program exists.

In a study measuring elderly people's quality of life in Osun State, those persons who had more access to financial resources reported the highest quality of life. These were mostly business owners who not only had more access to resources, but also had control over these resources. This group received more care, had better housing and nutrition, and got more support from family. Interestingly, those elderly people at the highest SES claimed they had the healthiest social relationships, while those elderly at the lowest SES were often ignored by their families (B. Fajemilehin & Odebiyi, 2011).

The most common causes of morbidity for the elderly in Nigeria are hypertension, cataracts, arthritis, anemia, and obesity (Adebusoye, Ladipo, Owoaje, & Ogunbode, 2011). Elderly persons with chronic disabilities are most disadvantaged. One study found that elderly persons who were very dependent received fewer cash transfers from younger relatives. And while many older adults live with younger generations in the home, this does not ensure the older person will be well cared for, especially if the household is in a lower SES gradient (Abidemi, 2005). Some elderly are indigent and rely on charities, churches, and neighbors for survival (Uwakwe et al., 2009).

One of the most significant challenges for the elderly in sub-Saharan Africa is adequate nutrition. In a study completed in 14 African countries, prevalence of an underweight body mass index (BMI) among the elderly ranged from 6% in Cameroon to 48% in Ghana. Nutritional intake was also of sub-standard quality. Most older adults reported eating mostly plant proteins, with few reports of animal protein. Consumption of fruits and vegetables was also low. Food insecurity was

common, affecting over 50% of elderly households. Inter-seasonal changes in BMI were often reported in areas where subsistence farming is the primary source of food (Kimokoti & Hamer, 2008).

Health care spending in Nigeria is mostly out-of-pocket, with only 2% of the population utilizing primary level free government-run health facilities (Uwakwe et al., 2009). There is a national pension system, but only a small number of the working population is covered. Essentially, Nigerians can put their earnings in a fund and are given a bond by the federal government. At retirement age, the bond and interest are returned to the contributor. This system is problematic because government and private financial systems are unstable and at times, outright dysfunctional (Casey, 2011). Nigerians receiving money from a pension is estimated to be around 1% (Uwakwe et al., 2009). Barriers to health for the elderly are significant in Nigeria and are exacerbated by a lack of government policies or programs catered to their needs.

The Informal Health Care System

Role of Children

Family, and especially the child-parent relationship, serve an important function in the Nigerian context. Essentially, a parent transfers goods and services to a child over the course of a lifetime and expects benefits in return for that investment. Fapohunda and Todaro refer to this as the "parent-child contract". Children may contribute labor to household enterprises, act as a revenue stream, and care for parents as they age. For the majority of families, these investments are made in male children because they have higher earning potential. Female children can fetch an attractive bride price, providing a large, one-time source of income (Fapohunda & Todaro, 1988).

These findings originate from the work of demographer J.C. Caldwell, who developed a concept called wealth flows theory. In this theory, Caldwell argues that the reason fertility rates are

not declining in some areas is due to economic reasons, rather than health or family planning reasons. Most relevant for our purposes here is the discussion of children as insurance against destitution in old age (J. C. Caldwell, 2005). Ronald Lee, expanding on the work of Caldwell writes that in situations in which formal insurance and savings accounts may be unavailable, "children may still be the best deal around" (R. D. Lee, 2003). While children certainly act as consumers within a household, they are seen more as contributors to household wealth than limiters.

Caregiving

Care of elderly persons is primarily the responsibility of female immediate family members. Care provided by immediate family is supplemented by support from extended family networks. Average household size is six members and is oftentimes multigenerational. High fertility rates mean there are typically many children and grandchildren to care for elderly relatives (Aboderin & Beard, 2015). The most common form of caregiver support are hired domestic workers or private nurses (Uwakwe et al., 2009). Conversely, elderly persons not in need of care may be caregivers themselves. Some may care for children, an older spouse, or neither.

Institutionalization of the elderly is uncommon for a variety of reasons. First, there is a lack of long-term care facilities in Nigeria. Some estimate there are less than 10 facilities, others say up to 25 (Akanji et al., 2002). Most institutions are run by Catholic missionary groups and the few beds available are reserved for only the most indigent. Cultural beliefs around family responsibility to the elderly contribute to a stigma of institutionalization and of families who institutionalize their relatives. It is perceived to be more respectable to die at home than in a hospital. In most cases, the immediate and extended family network function in tandem to ensure the elderly receive adequate care. But in some places, these networks are deteriorating due to the urban-rural migration of younger generations (Ogunniyi, Hall, Baiyewu, Gureje, & Unverzagt, 2005).

Conceptual Framework

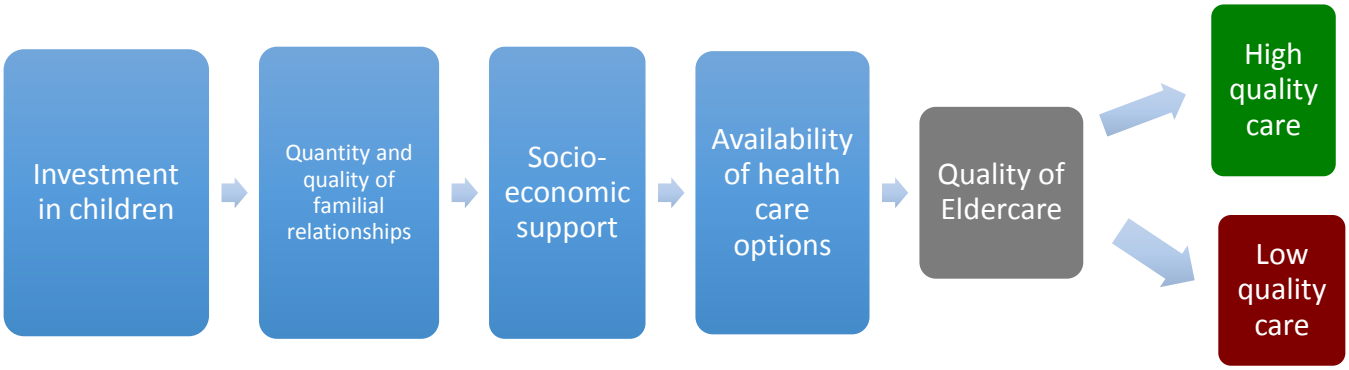

Figure 1. Conceptual framework describing the quality of care pathway for elderly persons in Nigeria.

Figure 1 shows the quality of eldercare pathway operating in Nigeria. The blue boxes represent a sequential pathway toward quality of care, represented in gray. For the purposes of this framework, the result is either high or low quality of care. Someone who has invested in their children may have many high quality familial relationships. This person is likely to have a high degree of financial support as children and extended family send money or provide care. This person also has a variety of health care options (public or private) and cost does not prevent them from getting the services they need. Their overall quality of care is high.

A person who has few family ties, may have little socioeconomic support. This person may have no other sources of income and this restricts their healthcare options. They may self-medicate with native remedies or not seek healthcare at all. This leads to overall low quality of care. Abuse and neglect is encompassed within low quality care.

Conclusion

This literature review provides a basic scope of what is known about aging in sub-Saharan Africa and specifically Nigeria. A limitation of this review is that there is little research on aging from this part of the world. In focusing on Nigeria specifically, there is much more research and scholarship around aging than in other sub-Saharan African countries due in part to Nigeria's strong academic tradition. The University of Ibadan has a geriatric center and much of the research seems to take place in the southern part of the country, where the University of Ibadan is located. The majority of aging research takes place in predominantly Christian areas among the Yoruba and Igbo peoples. These tribes are very different culturally from the central and northern regions of Nigeria. Because of this limitation, the research collected here may not be generalizable to the whole of Nigeria because cultural norms vary significantly by ethnic group.

Data collected for this project includes the southern part of the country, but centers around Plateau State, located in the north-central region. This will add geographic and cultural diversity to the existing body of literature. In addition, there are some quantitative studies describing the health of the elderly in Nigeria, but few qualitative studies, especially with caregivers of the elderly. The findings of this study can be used to support or refute quantitative research and generate questions for further exploration.

Methods

Introduction

The purpose of this project was to understand how the perceptions of quality of eldercare differ across three participant groups. These groups are the elderly, their caregivers, and change-makers. A caregiver is someone without formal medical training and is often, but not always, a member of the elderly person's family. 'Elderly' and change-maker are defined below. It is important to keep in mind that the concept of 'family' in Nigeria is fluid, oftentimes with hazy borders. Family networks are continually expanding and contracting, moving beyond 'blood relatives' and 'relatives-in-law' to include distant family and community members. When 'family' is referred to in this research, it is with this fluidity in mind. While this research was not conceived as a social network analysis, we believe it will speak to the commitment required to care for an elderly person in an environment where there is minimal institutional support.

Study Design

The study population comprised two main groups: elderly participants and those caring for an elderly person. The intention of the research was to capture the experiences of participants in their own words and was ideally suited for qualitative research methods. In-depth interviews (IDIs) were selected to provide a nuanced, individual perspective on aging and caregiving. Focus group discussions (FGDs) were conducted to understand community-level experiences of aging. Elderly participants were divided into two age categories for FGDs: 50-64, and 65-75. Because life expectancy in Nigeria is approximately 59 years, we were concerned about finding third and fourth age participants (Salomon et al., 2013). We used age 50 as a cutoff point to account for a potential lack of people aged 70 and above. We also wanted to separate those who were above and below the

official retirement age of 65 (Eme Okechukwu & Ugwu, 2011). This way, we could look for patterns among those who had retired and those who had not. Those older than 75 participated in an IDI rather than a focus group. Due to increased risk of frailty at older ages (Walston et al., 2006), we felt that older participants would be more comfortable being interviewed in their homes. To understand

Figure 1. Geopolitical zones of Nigeria and selected study sites (Fritz, 2016). Study sites are in red.

how communities and family networks care for the elderly, we conducted FGDs with caregivers in the same study sites. The eligibility criteria for caregivers was deliberately broad. We chose an upper cutoff of 50 years to keep our elderly and caregiver groups separate, while recognizing there are certainly persons older than 50 caring for elderly relatives. In addition, we asked participants if they

were caring for an elderly family member before beginning an FGD, but did not ask details about how the person was related as part of the selection process.

Key informant (change-maker) interviews were conducted to add context to the data from the FGDs and IDIs. We conducted key informant interviews with health professionals (physicians and nurses), policymakers (local, state, and national levels), and community leaders. These participants were selected from differing levels of influence to provide as much breadth on the topic of aging as possible.

The study took place in three states: Abuja Federal Capital Territory (FCT), Plateau State, and Ondo State. These states were chosen to maximize the geographic and cultural diversity of participants. Our in-country partner, Common Heritage Foundation (CHF)[1], also had community representatives in these areas. Plateau State and Abuja FCT are in the north central region of the country and Ondo State is in the southeast region of the country. Despite its name, the north central region is located in the middle of the country. Figure 1 shows the geopolitical regions of Nigeria and the study sites. Ideally, we would have collected data in more northern regions but due to safety concerns, we were not able to gain access to these areas. The demographic makeup of Plateau State is indicative of its place as a crossroads between the northern and central regions. The northern states are majority Muslim, while the south and central states are majority Christian and the culture reflects a combination of these religious traditions. Because Plateau state has a higher proportion of Muslims than Abuja FCT or Ondo state, we selected it to add religious diversity to our study sites (Agbiboa, 2013).

[1] Common Heritage Foundation (CHF) is a non-profit, non-governmental organization founded by Dr. Oladele Akogun and based in Abuja, FCT. Their mission is to "contribute to the enhancement of human capacity by increasing access of communities to basic services in education, health, food, and the good things in life." (Common Heritage Foundation, 2015)

After study regions were selected, we chose both an urban and rural location in each region to investigate whether patterns would emerge. In total, there were six study sites over three states. The study team's goal for each of the six sites was to conduct three FGDs with elderly participants, three FGDs with caregivers, and five IDIs with elderly participants. After discussing the eligibility criteria with CHF, it was decided that conducting FGDs with participants aged 50-64 was not necessary because we would have a sufficient number of participants 65 and older. Participants within communities were chosen with the help of gatekeepers who had worked previously with CHF. These gatekeepers lived in the target communities and were familiar with families living in the area. To recruit participants, the study team met with gatekeepers to discuss eligibility criteria. After this meeting, gatekeepers went to gather eligible people from the community to participate in FGDs. Gatekeepers were told to recruit 4-8 caregivers of elderly people per group. The group typically gathered within one of the participant's family compounds. For IDIs, the gatekeepers escorted the interviewers to homes where an elderly person resided. After the interviewers introduced themselves and were invited in, an informed consent discussion took place and the interviews began. When community leaders were available, we interviewed them as well. In addition to speaking with participants, we spoke with policymakers and health professionals to get their perception on the state of eldercare. We chose these informants through gatekeepers and from interviews with previous key informants. Change-makers and community leaders were given a small gift of appreciation after the interview.

At each study site, our goal was to conduct five IDIs with elderly participants, three FGDs with elderly participants, and three FGDs with caregivers. This would result in thirty IDIs, and eighteen FGDs each for elderly and caregiver groups. Key informant interviews were conducted as the opportunities became available, but at least one change-maker was interviewed in each community. A large sample size was chosen because both the elderly and caregiver participants were

heterogeneous in regards to ethnicity, religion, geographic location, and socioeconomic status. In addition, perception of eldercare is a more broad and complex topic, so we wanted to allow for sufficient diversity of opinion. For data analysis, a subset of the IDIs and FGDs with the most complete and rich data were chosen.

After a certain point in data collection, similar perceptions of eldercare began to emerge among both caregiver and elderly participants. Important to note is that the original data collection for this project covered a range of topics, everything from personal health status, to suggestions for improving the eldercare system, to perceptions of the aging process itself. While saturation was not reached on all of these topics, saturation was reached on perceptions of the quality of care of the elderly. Many of the participants had strong opinions about the health care system and were eager to share their views. For example, topics like primary health care reached saturation fairly quickly because there was less diversity of opinion on quality of care. The role of informal (family) caregivers took longer to reach saturation because there was more diversity of experience on this topic.

Instruments

The in depth interview and focus group discussion guides were prepared based on a preliminary literature review of the topic. Focus group guides for the elderly and caregivers asked about community support, caregiving, health care options and experiences, perceptions of challenges faced by the elderly, attitudes about aging, and potential solutions to the challenges discussed. IDI guides for the elderly asked about personal history, health care options, daily life, and care received from family. Questions were phrased in colloquial language to ensure that participants of all literacy levels could understand the questions. The use of colloquial language also helped build rapport between participant and interviewer. CHF reviewed the guides for cultural relevancy. The key

informant interview guides were completed in country at the suggestion of the CHF and consisted of more general questions designed to be probed further. For these guides, we included questions about the change-maker's role in their organization or community, their interactions with elderly persons as part of that role, and their opinions about the state of eldercare in Nigeria. Inexperienced facilitators were trained at the study office and experienced facilitators were briefed before beginning the IDIs and FGDs. Included in the training was practicing simultaneous translation of the guide to the language of the participants.

As discussed in the previous section, facilitators worked in tandem with gatekeepers in selected communities to identify potential participants. Informed consent was obtained from the elderly and caregiver participants before beginning an IDI or FGD. These were tape-recorded with the consent of the participants. Interviews and focus groups took place in the language of the participants and facilitators were fluent in these languages. IDIs and FGDs were conducted in Hausa, English, Gbagyi, Yoruba, and dialects of Yoruba. Some participants spoke more than one language or dialect and in this case, gatekeepers would remain on hand to translate so that questions could be asked in a supplemental language if not understood the first time. IDIs and FGDs were transcribed directly from the language in which conducted to English by the facilitator who conducted the interview or discussion. Due to the involvement of human subjects in this research, IRB approval was needed. All study materials were granted expedited approval by the Institutional Review Board at Emory University and the National Research Ethics Committee of the Federal Ministry of Health of Nigeria.

Data Analysis

For the analysis of the data, a thematic analysis approach was used. Because this project was formative research, we were interested in generating hypotheses for further study and identifying

themes and patterns throughout the data. It was not our immediate goal to generate a theory to explain our findings, which would have dictated a grounded theory approach (Guest, MacQueen, & Namey, 2011). In this case, we wanted to understand the context of aging in Nigeria and sought to compare perceptions of the informal and formal health care system.

After the data were prepared, all transcripts were memoed to identify issues and themes emerging form the data. Memoing is a process in which notes are written on the data itself and are used to reflect critically on the data and develop codes for analysis. One third of the transcripts were used to develop codes and were selected for diversity of content to allow for breadth of code development (Hennink, Hutter, & Bailey, 2010). Using memos, findings from previous literature (deductive coding), and the data itself (inductive coding), codes were developed and modified in an iterative process. Once these codes were developed, a codebook was created in which these codes were defined in detail. To code the transcripts, selected blocks of text were categorized under one or more codes. Transcripts were coded twice to ensure that all text segments relevant to the research question were coded. In addition, some code definitions were changed throughout the coding process, so codes that had been altered were given an additional review. All analysis was completed using MaxQDA software. In total, this analysis used two FGDs from elderly participants, six IDIs from elderly participants, ten semi-structured interviews with key-informants, and five FGDs with family caregivers.

WHO Framework

The WHO's Six Dimensions of Quality of Care listed below were used to guide deductive analysis of the data. When deciding whether or not to code a text segment, I broke down each definition into its component pieces. If a text segment satisfied one of the pieces of the definition, it was coded as such. For example, the first quote in the table below was sub-coded as *effective* because

the hospital medicines are not working, meaning that the prescription may not be evidence-based and is certainly not results-based in the case of this individual. It is important to note that dimensions were coded as both presence and absence. A text segment was sub-coded as *effective* when a participant described both effective and explicitly non-effective care.

Dimension of Care	Definition	Example
Effective	Care is needs-based, evidence-based, and results-based.	"I have tried hospital medicines to no avail and it is not working."
Efficient	Care provided maximizes resources and minimizes waste.	"Normally their family take that responsibility, take them to the big-big hospitals in the town. So they are not eh optimizing this uh this primary health care."
Accessible	Care is timely, geographically reasonable, and provided in a setting where the skills and resources are appropriate to the medical need.	"Before going to the hospital, you check if you are having transportation. If there is, you go and buy the drugs but if there is not, you just have to stay at home."
Patient-centered	Care takes into consideration the aspirations and preferences of individuals and cultures of communities.	"We sit together, watch movies or if there's no light, just sit together with them. It relieves them of tension. And then they always like their children being around them."
Equitable	Care should not vary based on gender, race, ethnicity, geographic location, SES.	"They have their own aged people they care more or attend to people in their community first before people from other community."
Safe	Care should minimize risk and harm.	"They depend on native treatment and native there is no measurement for example no accurate prescription and when you take it results in side effects."

Table 1. The WHO's Six Dimensions of Care Framework, definitions, and examples from qualitative data (World Health Organization, 2006).

Table 1 shows the WHO's Six Dimensions of Quality of Care framework and provides quotes that exemplify each definition. This framework was applied to the data to provide clarity on what types of descriptions provided by participants constituted a discussion of quality of care. Each dimension of quality of care was created as a sub-code in MaxQDA. The data were coded deductively with these sub-codes, and also with codes from the literature and the interview guides. Some of these deductive codes included: *primary health care*, and *public vs. private healthcare*. Inductive codes were also generated from the data including *abuse and neglect* and *native medicines*.

After coding, the data were searched by code to gain an understanding of the variations within the data. For example, the code *native medicines* was retrieved from all participants groups and read in detail to explore the data. This process was repeated with all codes relevant to the research question. In the process of searching, the breadth of perceptions began to emerge. Additional readings revealed depth of these perceptions. To gain nuance, data from each participant group were isolated to see how each group thought differently about the same topic. For example, data from the *family care* code was read for change-makers, elderly participants, and caregivers separately. This same process occurred to gain context that would inform the research question. These codes included *the youth, society's view of the elderly,* and *policies and programs*. While these codes did not directly answer the research question, they provided a more complete understanding of the emerging themes.

To compare the quality of care dimensions across groups, segments of overlapping codes were extracted from the data. For example, an overlap of the codes *primary health care* and *efficiency* equated to a participant discussing their perceptions of the efficiency of primary health care. These

overlapping coding segments were then analyzed within each of the three participant groups (elderly, caregivers, and change-makers) and then across groups. To validate these comparisons, I reread the sections of text that the coded segments originated from to ensure I was interpreting the participant's meaning correctly. In order to structure the results, colored categories were created in MaxQDA to group codes together. These categories were 1) contextual codes, 2) codes that answered the research question, and 3) codes that were influencers of the research question that I wanted to weave into the results and discussion. To conceptualize the data as a whole, I thought about how each code fit into the conceptual framework presented in the previous chapter. The data followed the quality of eldercare pathway synthesized from the literature, but added more nuance to each box, especially low-quality care.

Limitations

One limitation of the study design is that we were not able to include northern regions in the study. This would have increased the diversity of our data, especially considering there are approximately equal numbers of Christians and Muslims in Nigeria (Agbiboa, 2013). We were able to conduct two focus groups in Muslim communities and the themes differed when compared to FGDs conducted in Christian communities. Including more Muslim communities would have allowed us to explore these unique themes in more detail. Another limitation is that we often defaulted to convenience sampling rather than purposive sampling. Rather than selecting participants for diversity, in some cases, we selected participants because they were available to participate in a focus group discussion or in-depth interview. In regards to the key informant interviews, the opposite was true. Our change-makers were selected to answer questions that had arisen in previous interviews and to fill gaps in knowledge. Convenience sampling did not impede the validity of our results because the data were gleaned from a variety of different geographic locations. A lack of site-specific diversity was ameliorated by diversity of geographic region, which in

the context of Nigeria, equates to diversity of ethnicity and in some cases, religion. Nigeria has over 250 ethnic groups and study sites in non-contiguous states contributed to the diversity of the data (National Geographic, 2004).

Given time constraints, IDI facilitators were trained quickly and may have benefitted from a more intensive training process. In addition, it would have been beneficial to have the guides translated in the languages of the IDI or FGD so facilitators did not have to simultaneously translate, even though we had practiced beforehand. Facilitators would have also benefitted from greater discussion of the research questions so as to provide a 'big picture' view of the goals of the study.

Results

Introduction

The results section is structured in two parts. First, I will describe contextual factors within the data that will enhance understanding of the results. When appropriate, I will use the participant's own terms to describe the elderly as a demographic group. These terms include 'the aged', 'the elderly ones', or 'the elderlies'. The second section of this section will attempt to answer the research question: how do perceptions of quality of care for the elderly differ among the elderly, their caregivers, and change-makers (health professionals, policy makers, and community leaders). Each sub-section indicates a theme explored in the data.

Background Context

Society's View of Aging and the Elderly

To begin a discussion of quality of care for the elderly in Nigeria, it will be important to understand how Nigerian society values or does not value being an elderly person, or aging in general. Participants described their views on aging or being an elderly person using three lenses: neutral, positive, or negative. Using a neutral lens, participants attached neither positive nor negative value to aging, but were stating facts or perceived preferences of the elderly. The second lens positively values the experience of aging and being an elderly person. The negative lens was applied when participants described aging as a negative experience. In this lens, participants mostly reflected negative values they knew to exist in society, rather than their own personal views. These lenses are used only in this section.

To start with the neutral lens, all three participant groups described the role of elders as counselors to younger people. In some cases, the elderly served as parental figures for nieces and

nephews or became parents again if grandchildren had been orphaned. It was also universally acknowledged that the elderly prefer to live in rural villages rather than urban or peri-urban areas. This preference was humorous to some:

> "If you go to the village and take her [elderly grandmother] to the city, tomorrow she will tell you she's sick. [*Laughing*] And after she is saying she's sick, and you are thinking as if she's playing – she's joking. It's another issue. So the moment you take her to the village, she's well. And after that she's telling you that she's OK. She's in the bush tomorrow." *(FGD, caregiver, rural village)*

Villages are places where people live out their last years. Two participants insisted there were residents above 120 years in their villages. Many elderly people are unsure of their numerical age. A doctor noticed that those who live in rural areas tend to look older than they really are. Considering these factors, being an 'elderly' person is not determined by numerical age, but on a person's physical appearance, health status, and experiences. For example, being elderly or 'an elder' is synonymous with wisdom or community leadership. But in other cases, someone who is sick or physically weak may be considered elderly even though they are not of advanced numerical age.

Being an elderly person is a privilege and a blessing. As such, elderly people should be respected and listened to, especially when they offer advice or stories. Elderly participants are caregivers to children and spouses, advisors to younger generations, and peacekeepers of the family and community. One young participant described his attitude toward the elderly as such:

> "Even the respect – you have to – when you see somebody who is elder or is old one, old man, old man – he is your father per say. Like conduct, you say 'Baba, baba, baba'. You call him 'Baba'. Everyone is Baba. And you respect him the way you would respect your own father." *(FGD, caregiver, rural village)*

While most participants expressed valuation of the elderly, some noticed that a shift was taking place. Participants referred to a past time when the elderly were better respected than the present day. This growing lack of respect was not viewed as a benign expression of youth angst, but as a startling ambivalence to traditional values that had dangerous consequences for elderly family members.

This ambivalence was reflected in the participant's discussion of opinions they had heard in their communities. The prevailing negative viewpoint was that at a certain point, the elderly cease to be useful. This point occurs not at a certain numerical age, but when the elderly individual becomes too burdensome on the rest of the family. Below are examples of this attitude as told by participants:

- "We should put our strength where we can get meaningful out – output and not for those who have already enjoyed their life and they are on their way out."
- "Ah my mother has been blind and after all that's part of aging and she's – I'm taking, providing all her needs. Why should I bother myself?"
- "Why not just let them die so that we bury them and forge ahead?"

While these were not the participant's own views, the participants did feel negatively about aging when looking toward their own future. Some participants feared their own aging process, using their experiences as caregivers as a reference. They worried their children would neglect them when they were older and did not want to burden their families. According to one group of caregivers in their 20's and 30's, 'old age' is not in the distant future – someone could be considered old as early as 40 depending on their physical health. As an example, if a person was a farmer or a laborer, their health would begin to decline at around 40 or earlier. Someone who was eating well, "living fresh", and "doing light-light things" wouldn't decline until their 50s. Because old age and physical infirmity were almost always discussed as mutually inclusive, one focus group was asked:

I1: Are there people here who are in this community who are old and not sick?

R1: No.

R4: There's no person like this.

R6: It's impossible. *(FGD, caregivers, urban).*

In some cases, being elderly and therefore sick was not only defined by the visual appearance of sickness, but also by less obvious morbidities like high blood pressure or diabetes. Regardless of the specific malady, sickness, weakness, and age were closely linked concepts.

The effects of devaluation of the elderly manifests most clearly for medical professionals. They acknowledged that many of the elderly patients they came across in their practices were suffering unnecessarily. In some cases, an elderly person's complaints about aches and pains were viewed in the realm of normal behavior and not taken seriously. Some elderly had no family or transportation to access care at all. In other cases, a family might value better care for their elderly one, but not be able to afford it. These medical professionals noted that many of their elderly patients could have lived longer had they received the care they needed.

A Child's Responsibility

Cultural traditions dictate that it is a child's responsibility to take care of their parents and grandparents as they age. Because there is no form of public social support available to the elderly in Nigeria, the only income many elderly people have is that of their children. Investing in a child by paying school fees, for example, is a way for parents to increase the likelihood that their children will be wealthier and that parents will be more comfortable in old age. In talking to elderly participants, large medical expenses were typically paid for by adult children, with two exceptions. One exception was a participant whose wife had passed and had no children. He was dependent on the kindness of strangers for income. Another exception was a man who paid his own medical expenses, but became

impoverished as a result. He had been a wealthy construction contractor, but after an accident was hospitalized for 20 months and sold all his property to pay for care. Some elderly participants generated income from other sources: pensions, selling firewood, or farming. However, in the majority of cases, children were the sole source of income for the elderly. Those who received financial support from children were not only grateful for the material assistance, but were also grateful that their children were an active part of their lives.

There are many reasons why an adult child may not financially support their elderly family member. The most common reason is a lack of money or the need to prioritize infants or young children over an elderly person in the household. Another reason may be resentment that parents never invested in children in the first place. One young man in Abuja, FCT put it this way, "…not all parents care for their children. They may care for one and leave the other ones. And they may be bad people too." Strained relationships may be another reason a child would not fulfill an obligation to provide for parents. When children do not fulfill their obligations, conditions within the household can deteriorate. One elderly participant described it like this:

> "If they [children] leave the community -- go out -- they do not concern themselves with building a nice place for the old…Secondly, they do not take care of toilet or water to drink. If they construct a well in the house, it falls so they just go to the river and there are many diseases. An old person at this time needs blanket and to take like tea so that they will be warm…At times if you have a child in senior service, he just takes care of himself. He just stays at Abuja. It is really disturbing to us. Many a times we need help. You know, dying is different with no one to help. You want to eat, no food. No health in our bodies." *(FGD, elderly, rural village)*

In addition, elderly participants reported that the community sometimes shamed families whose children were absent. This mechanism worked in two opposing ways. One participant reported that community members mocked an elderly individual whose children had left them, blaming the abandonment on the parent themselves. Conversely, a community created a song to guilt a family into taking better care of their elderly one. The shamefulness of shirking familial obligations may work at a subconscious level as well. One elderly participant, while describing youth in the village who did not care for their parents, lowered her voice to a whisper, even though the interview was being conducted in a private room.

Participants in the elderly, caregiver, and change-maker groups all agreed on why youth were absent; they moved to cities to seek economic opportunities. When asking youth why their peers move to the city, they cited high poverty in rural areas as the main motivator. After time spent in the city, young people may return to the village with more wealth, bringing food and gifts for their families. Other youth in the community see the gains of their peers and seek the same for themselves. In some cases, parents may receive enough money from children in cities to be comfortable, but geographic separation of families can be emotionally stressful for the elderly and their children alike. The effects of absent or infrequently-visiting children on the elderly was described by a home health provider:

> "What of the old ones whom their children, whom they give beds to, have abandoned in their respective remote areas? Went to cities to look for money. They are there gnashing their teeth…Send like bag of rice or money to them. But what of, I mean, that relationship – the child parent's relationship? Emotional feelings, psychological, they don't – no longer see them. Food may be there, but because of emotional problem, some of them even die of

boredom. Some become ill and nobody take them to hospital." (*change-maker, home-health provider)*

In some cases, lack of involvement by children in their parent's lives was seen as a direct contributor to a parent's death. While some communities were able to support indigent elderly through religious institutions or pooling of group resources, elderly people with no access to the community's informal safety net may indeed pass away as a result of poverty and lack of access to care. The exact mechanism by which the elderly deteriorate due to absent children is unclear, but all participants linked the economic status of adult children directly to the health of their elderly parents, and in some cases the whole family.

What about youth who *do* fulfill familial obligations? Many of the youth described the care they provide to their elderly ones as a blessing, while acknowledging that they too will be old and hope for the same quality of care from their loved ones. Elderly participants who felt well cared for by their families attributed their sense of wellbeing to the education of their children. Returning to comments made in the beginning of this section, some parents sought to keep their children in school for as long as possible so they would have higher earning potential to support the family. Secondly, parents instill in children at an early age that it is their responsibility to take care of the older generation. Youth grow up hearing these messages of 'care reciprocation', as this chief describes:

"We have often sat to talk to the youth so that they understand exactly their responsibilities. Because uh if your father took care of you from your – when you were very young, when you were given birth to, and you've been able to grow to a level – he has trained you, sent you to school, done almost everything, given you everything that you require. But uh when

he is no longer strong enough to be able to maybe fend for himself and you are not there for him, God is going to judge you for this." (*change-maker, chief, rural village)*

In addition, in families where there are multiple adult children, responsibility for the elderly one is shared across the children. This will be discussed in more detail in the next section, but in most cases a division of labor among adult children takes place. For example, a son who lives far away may financially support the family, while a daughter who lives close by may be seeing to the day to day care of an elderly relative.

Children or grandchildren of elderly people serve their loved ones in a variety of ways. They provide direct care, advocate for their loved ones, send money, listen, and much more. But as economic conditions in Nigeria have deteriorated, so have familial relationships, which have a direct impact on the health and wellbeing of the elderly. Lack of social welfare programs have left younger generations as the sole source of income in some cases. Decreased incomes also influence the elderly's interactions with the health care system and their perceptions of the quality of care they receive.

Programs and Policies

As part of this project, we spoke with policy makers at local, state and federal levels to determine what policies were in place to support the elderly and improve their quality of care. Among state and local policymakers we spoke with, none had policies or programs specifically dedicated to eldercare. As a reminder, there is no social welfare program at the federal level to support the elderly. Some civil servants do receive pensions, but these are often delayed or never received. At the federal level there were several policies at various levels of implementation. The National Council on Health established a directive in 2012 that all federal tertiary-level institutions should have a geriatric center. As of summer 2016, one had been established at the University of

Ibadan. A poverty alleviation program, still in its early stages, would provide a monthly allowance for the poor and the ministry hoped that this program would reach the elderly. A Ministry of Health official also mentioned a new approach to providing income for older adults that taught them crafts and skills like hand-weaving and gardening. It was unclear if this was an official government-sponsored program.

Eldercare technically falls under the Ministry of Women's Affairs and Social Development. This ministry completed a draft policy on eldercare in 2008, but had not received funding for implementation. This policy included programs for skill acquisition, health, and housing. The ministry had implemented sensitization campaigns on elder abuse and handicap accessibility using radio and television messaging. In the past, the ministry supported individual eldercare institutions by giving televisions, food, and mattresses. According to a ministry official, there are 25 eldercare homes in Nigeria. There are no geriatricians, which was corroborated by all the health professionals we spoke with. The University of Ibadan has a well-regarded geriatric center and while there are no physicians trained in geriatrics, many of the doctors there conduct research on eldercare.

Perceptions of Quality of Care

In the literature review of this paper, I discussed the administrative structure of the health care system in Nigeria, but for clarity's sake, I will briefly review it here. The primary health care system is managed by local government areas (LGAs) and provides basic services like typhoid and malaria treatment. Secondary-level hospitals are managed by state government and provide more comprehensive services such as minor outpatient procedures. Tertiary institutions are managed at the federal level and include teaching hospitals. Separately, the private healthcare system also operates at all three levels of care and includes clinics, general hospitals and specialty hospitals. Health facilities typically follow a fee for service model, although referrals are needed for some

services. Prescriptions can be purchased from health facilities or chemists (pharmacists). Some also utilize native medicines, which are typically herbal teas or drinks.

As discussed in the Methods section, I have applied the WHO's Six Dimensions of Quality framework to the data when applicable. These six dimensions are: effective care, efficient care, accessible care, patient-centered care, equitable care, and safe care. These sub-codes indicate both presence and absence – a section was coded as safe, if the participant was describing something safe or unsafe. Codes were created for PHC, private, and public healthcare, in addition to native medicines (inductive), and informal care. To answer the research question, I sought places where the health care system codes overlapped with WHO's quality of care sub-codes. A section of the health system was considered as coded under the one of the six dimensions of care if there were four text segments with overlapping coding. For example, if the *PHC* and *efficiency* codes overlapped in four different text segment, efficiency in PHC was analyzed. This analysis involved reading and re-reading of these text segments to understand how PHC is or is not efficient. Next, I compared these perceptions across participant groups: the elderly, their caregivers, and change-maker (policymakers, health professionals, and community leaders). I will begin by discussing the formal healthcare system and move into the informal healthcare system, which is more difficult to interpret within the WHO's framework.

Primary Health Care

Regarding overall satisfaction with primary health facilities, elderly participants were largely unsatisfied with the services they received, with one exception. One participant who lived in a small village said that when she goes to the primary care facility, "they will answer me…they will show love to me". Otherwise, elderly participants were unhappy with the quality of care they had received. One older man mentioned that the health facility workers "attend to people in their community first

before people from other community". Caregivers also did not think the primary health facilities were up to par, but were quick to say that the staff was "doing ok. They are trying." During focus groups, caregivers typically started the discussion saying that primary care facilities were doing their best. By the end of the discussion, caregiver's opinions of the facilities devolved into more obvious dissatisfaction. Among their complaints were that the equipment was not appropriate for areas with frequent power outages and widespread personnel shortages. Some mentioned that primary health facilities were able manage some morbidities well, with the help of outside funding:

> "…what we know is that if the problem is pandemic or an epidemic, we will see some health care coming from somewhere we don't know…like this polio or something, I don't know, I don't, this one is not government something. I think it's UNICEF or something like this…But this the the kind of this problem of maybe giving bread to children or something like that, you know that one is different. So the primary health care is helping. It is beyond their control." *(FGD, caregiver, rural village)*

Even health professionals acknowledged that primary care is lacking, especially in rural areas. While it is a cultural norm and preference for the elderly to move to the village for their last years, some linked this practice with increased morbidity and mortality. One doctor in the Abuja recalled this warning, "…my mother was warning us, 'When you retire, don't – don't go the village. Don't do what our people do. You just go and die there.'" To mitigate some of the effects of lack of access, children living in the city will take their elderly ones for check-ups in urban areas when they come to visit. But in both urban and rural areas, those in need of care often bypassed primary health care completely, choosing to go straight to a secondary- or tertiary-level public or private facility.

In regard to the WHO's dimensions of care, primary health care was coded with the *efficiency*, and *effectiveness* codes. Primary care facilities were widely regarding as inefficient in the sense that they

do not maximize health care at the local level. Health care professionals agreed, saying that there is not much that primary health facilities are able to do in-house. Caregivers noticed that most who were going to primary health facilities were being referred up to higher-level institutions, "they have no qualified doctors or sometimes – I don't know. I'm not saying they don't have doctor, but why is it that people jump, normally jump somewhere to the private? That means here there's nothing." Broadly, participants agreed that the primary health system is not being optimized, especially because it may be the only health facility in a rural village. The perceived reason for the referrals was that care provided was ineffective, unless the diagnosis was malaria, typhoid, or a disease that was on international donor's or the government's radar.

Secondary and Tertiary Health Care

Overall satisfaction with secondary and tertiary institutions was also low, although for different reasons than primary health care. There was much more heterogeneity of opinion across participant groups. This section was coded with the *accessibility* sub-codes. For the majority of health care services, costs were out-of-pocket. For those with less money, this limited their health care options. Private hospitals were generally smaller, had shorter wait times, and were more expensive. Many specialist hospitals fell into this category. Public hospitals were larger and could be general hospitals or teaching hospitals. Even though public hospitals were significantly cheaper than private hospitals, some still found the cost prohibitive. This was the main contributor to participant's perception that secondary and tertiary healthcare was inaccessible. As with seldom-visiting or absent children, lack of money for healthcare was seen as directly preceding an elderly person's death, "When we are sick and we don't have money to go to the hospital, we suffer and die at home".

Not only were costs prohibitive, but elderly participants noticed that costs have risen. Some reminisced about the colonial period when public hospitals provided free health care. Free

medication would be provided by the hospital itself, with no additional trips to the chemist. In addition to financial inaccessibility, a significant amount of time was needed to go to a public hospital. A patient may line up at nine in the morning and not leave until two in the afternoon, not considering transportation. Getting to the health facility may be another barrier, depending on a person's level of mobility. One participant, with high mobility, described his journey to the hospital:

> "Let's say if you are going to Maraba General Hospital, from here you climb motorcycle at 150 Naira to Masaka U-turn. Then you enter motor vehicle at 170 Naira to Maraba. Then you climb motorcycle at 100 Naira to the hospital and you collect card for 300 Naira." *(FGD, elderly,, urban).*

Those living in rural areas not only had less choice of health facilities, but travel distances were longer and not possible for those with low mobility or low income.

While elderly participants spoke of the inaccessibility of health care in more fatalistic terms, caregivers spoke about the high cost's impact on the household. Caregivers were often parents themselves and needed to provide for children as well as elderly parents. One caregiver described how his financial situation affected the care he provided:

> "Financial support, because taking care of an elderly person – when you have, like me, I have two children, two kids. So there are school fees, tea for – tea and bread for the elderly and other things. That is where we find difficulties. Nevertheless, we are coping…What they want, they will not get it up to 100% because of the level of needs." *(FGD, caregiver, rural)*

Because of low household income, caregivers were often forced to prioritize the healthcare needs of different members of the family. In this equation, infants and children received larger shares of household resources, although this was mitigated in some cases by free healthcare programs for children.

The change-maker group did not speak extensively about the quality of care they provide in their facilities. This line of questioning seemed inappropriate, especially when change-makers were being gracious with their time. Despite this, some physicians offered their views on the accessibility of health care services. Two doctors in a private establishment said that some patients found their costs prohibitive so came once and did not return. These doctors acknowledged that their facilities were expensive, but mentioned that teaching hospitals were cheaper, for those who could not afford the private health care services. Despite public hospital's cheaper price tag, they were still financially inaccessible for some. The chief medical director of a tertiary-level public hospital told the story of an elderly patient presenting with a prostate issue:

> R: …his wife had left, the kids have – some in Lagos, scattered all over. It was neighbors that brought him. He had nobody. He didn't have any money. He had only 500 Naira in his pocket. That can't even buy catheter.
>
> I1: So how would he pay for care?
>
> R: That's the problem. So it is left for me to devise a way to take care of him. If I say this man should go, he definitely going to die…So we have to bulldoze our way to find a way of admitting him. For free. Based on just some of our own human passion. *(change-maker, Chief Medical Director, public hospital)*

Are elderly people without money left completely without health care options? Non-profits and non-governmental organizations have been working to provide health care for those who cannot afford it. One such organization is the Christian Health Association of Nigeria (CHAN). CHAN is an advocacy group that not only speaks to policymakers about allocating more funds to healthcare, but they also fundraise from Christian churches to support religiously-affiliated hospitals. These are technically private institutions and do charge for services, but they also provide care for those who

are unable to pay. Fundraising from churches helps individual mission hospitals pay the debts that arise from providing free healthcare to indigent patients.

In discussions of interactions with the health care system, caregivers did not report any experiences of equitable or inequitable care. The health professionals interviewed said they treated elderly patients the same as all other patients – equally. This was a problem for some elderly participants who expected to be treated inequitably – better than other patients because of their old age and health conditions. As mentioned in the 'Background Context' section, aged ones are to be treated with the utmost respect. In a healthcare setting this translated to preferential treatment for elderly patients. Participants were upset that they had been treated like everyone else because this amounted to disrespect of their status as an older person.

Native Medicines

All participant groups mentioned the use of native medicine by the elderly. Native medicine is the term used by participants, rather than 'traditional' or 'alternative' medicine. This medicine is usually a 'concoction' or tea of herbs obtained from an herbalist. This category of care was coded with the *safety* and *effectiveness* sub-codes. Most elderly participants used native medicines as a supplement to clinical medicine in two cases. First, when they perceived that the prescription they received from their doctor was ineffective and second, when the prescription was too expensive. Some elderly participants acknowledged that the native treatments may be unsafe, but they chose to use these anyway. One participant said that he drank the same concoction for headaches, toothaches and leg pains and that he sometimes experienced side effects like dizziness right after drinking the medicine. Participants used others in the community as resources for what herbs worked and for which ailments. One participant, while acknowledging that he used herbs himself, maintained that many in the community were ignorant because they were not aware of whether the herbs they used

were tested beforehand. Another participant said that although the practice of using native medicines had been passed down for generations, it could be harmful. Before one of the interviews, a participant mentioned he drank some herbs to control his blood pressure and that he had gotten so dizzy, he had to sit down.

Elderly participants had varying opinions about the effectiveness of native medicines. Several said that the "hospital medicines" did not work, so they began taking native medicines and were pleased with the result. Others said that they were unsure whether the native medicines worked. In this case, they added a different leaf to the concoction and waited to see if the ailment improved. Despite concerns about safety and effectiveness, the majority of elderly participants interviewed preferred native medicines to hospital medicines. Part of this may be the experience of visiting an herbalist, which the elderly reported as more pleasant than going to a clinic or a hospital. There were no lines at the herbalist and payment could be made at a later date, not immediately after receiving herbs or advice.

Health professionals said the use of native medicines was unsafe. One physician reported that patients would come to him after using native medicines because their condition had not improved or worsened. When the patients came in, he tried to educate them, but believed he had limited success because of the practice's strong association with tradition and culture. Caregivers regarded native medicine as a cheaper option to hospital medicines. Whereas, the elderly preferred native treatments, caregivers said that native treatments could be used as an alternative if someone did not have the money for hospital medicine.

Informal Care

Because much of care for the elderly in Nigeria is provided informally, I applied the WHO framework to the informal care system as well. Informal care in this context refers to any care

provided outside a medical facility by family or community members to an elderly individual. Perhaps unsurprisingly, the care provided informally closely aligned with the *patient-centered* sub-code from the framework. The elderly discussed patient-centered care in relation to food and nutrition. This narrative involved a spouse or child cooking food that the elderly person liked. In several cases, a wife did all the cooking, making sure to serve the specific tea that her husband liked. In other cases, getting food to eat was one of the most difficult challenges for elderly people. In farming communities, there may be only guinea corn to eat at certain times of the year. When an older man was asked what advice he had for the youth, he said to eat less sweets, because too much sugar consumption had affected him in his later years.

Caregivers said that their elderly ones preferred to eat carbohydrates rather than fruits and vegetables. This was attributed to lack of education and the need to quickly satisfy hunger with carbohydrates rather than obtaining nutrients from vegetables. In regards to household finances, eating healthy was described by some to be more expensive than eating less healthy. One caregiver, whose father was a diabetic, said she spent a lot of time and money making sure that he ate right. Other families prioritized who got to more expensive, nutritious foods. For example, tea and fish may be served only to young children and the elderly because it is too expensive to serve to everyone. Caregivers talked about the importance of healthy eating over a lifetime. They noticed that elderly ones who had eaten a more balanced diet over the life course appeared to be stronger at older ages than those who ate only carbohydrates. Those who were unable to afford meat or fish, added cheaper proteins like milk and beans to meals. In regards to timing of meals, caregivers reported that their elderly ones did not eat large meals at night because there was not enough time to digest the food before bed. It was unclear whether this was the elderly person's preference, a doctor's recommendation, or anecdotal knowledge.

Health professionals mentioned that malnutrition among the elderly is common. One primary care doctor said he visited the home of an elderly person who had not eaten for a month. This was a low-mobility, indigent patient whose children were absent. Home health providers said they could determine how educated a family was by what they were eating. Part of their service was to provide education to families on what the elderly should be eating – in their opinion – mostly vegetables.

Patient-centered informal care occurs when caregivers consider the preferences and desires of the elderly person in the care they provide. In some cases, preferences of the elderly regarding their own care were disregarded by caregivers. In one instance, a woman with a diabetes ulcer wanted to spend money on home health care with money she had been receiving from her children. The daughter responsible for sending money did not want the mother to pay for home health care. The mother died shortly after and the daughter blamed herself for her death. A story like this, however, is the exception.

The caregivers gave many examples of patient-centered care they provide to their loved ones. Most important is the decision about who will be the primary day-to-day caregiver for the older person. This is usually decided by the older person themselves based on who they are closest to. This could be a male or female child of any age. In some cases, it may even be a grandchild who provides care. For day-to-day caregiving, this was preferable because an elderly person and a grandchild may be more patient with each other than a child and their parent. In Muslim communities, the decision-making on who provided care was less flexible. Daughters-in-law would be the primary caregiver for elderly people in the husband's household, while the eldest son would be responsible for financial support of the elderly individual.

For elderly ones that had low mobility, families made deliberate efforts to keep them connected. In some communities, farmers may be in the fields all day. In one case, a young man gave his father a cell phone so that he could call if he needed something or wanted to check-in with his son:

> "Then uh we bought a phone for my dad for communication in case I'm not close. So he may call me and tell me this is what the sorts of thing I need at so-so time. Eh? Maybe he'll ask me, 'My son where are you? How are you? Fine.' And I will say, 'Dad I am well and you're fine. There is no problem. How are you Dad? Have you take your break? Have you take' -- all these things. We communicate. *(FGD, caregiver, rural)*

For elderly individuals with low mobility, caregivers sat with them in the sun to get vitamin D and feel the breeze. Others encouraged grandchildren to play in the family compound so the elderly one could watch and interact with the children. One caregiver watched movies every night with her father and when the power was out, they would simply sit together because he liked having her close. This form of patient-centered care is a reflection of youth fulfilling their responsibilities to parents, as discussed earlier. But of course, the primary motivator for this form of care was love and respect for the aged ones in the family. As one caregiver put it, "And another thing, you know at that age, you need love as well."

Abandonment of the Elderly

Throughout analysis of this data, one theme kept appearing time and again: abandonment and neglect of the elderly. Because this is a qualitative study, I can provide no information on how common neglect is among the elderly in Nigeria. However, the topic surfaced in almost every piece of data, often unsolicited. Elderly participants knew of people in their communities who were neglected and often thanked God that their own children cared for them. One elderly man with no

wife or children, depended on the generosity of his community to live. Later, he said that he had a brother farming in a nearby village. His brother's family moved because the soil was no longer fertile in their home village. This participant was still mobile and could walk around the community, although he has fallen many times as a result of "old age effect". People often gave him food or money and if he needed something specific from the market, he gave a neighbor's child some money and they would purchase it for him. This man had been to the hospital, but was not explicit about how he paid for services. Although this man's brother lived in another village and was not involved in care, the notion of having no family to provide care for an elderly person was unheard of. Extended families may number in the tens or hundreds of people, especially considering that family is not defined by blood, but by relationship and connection. Family always exists, but whether they are involved in care is a different matter.

Caregivers acknowledged that there were elderly in their community who had no one to provide care. They cited the attitude of their peers as a main contributor to the neglect of elderly people. The idea that the elderly were no longer useful and were a burden to families was common, according to caregivers. Some young people ignored offers of advice from older people, which as discussed previously, was deeply disrespectful. One doctor related that an LGA in which she served had an especially high prevalence of HIV among the elderly because young men were raping girls and their grandmothers during the day. Caregivers recommended doing a sensitization campaign to change the mindset of young people in regards to the elderly.

The change-maker group had the most to say regarding neglect of the elderly. For one state official, the informal care system was to blame for the negligence of older people. Because institutionalization is often unavailable and mostly stigmatized, the elderly are cared for in their homes. As the level of care for the elderly person increased, the quality of care would drop, and the

household would be unable to care for an individual. In cases like these, families may leave their elderly at local hospitals. Organizations like CHAN helped to provide financial support for hospitals who were providing care for indigent elderly patients. Another doctor mentioned she had heard of several cases of elderly people with dementia abused by their children. As discussed above, the Ministry of Women's Affairs had a sensitization program to combat elder abuse, but funding had not been available to continue the campaign.

Discussion

The Parent-Child Relationship

The results on society's view of the elderly presented in the previous chapter represent a departure from long-standing traditional values regarding treatment of the elderly in Nigeria. Many participants discussed the elderly in a positive light: older people serve as leaders and counselors to the community. The elderly may earn income, care for grandchildren, counsel the youth, and mediate disputes. Elderly individuals serve as the resource-persons of a community, as Aboderin and Beard write in *The Lancet*. They explain that older adults are essential to economic and human wellbeing, "despite common assumptions" (Aboderin & Beard, 2015). The use of this phrase in the article implies that some may believe just the opposite, that the elderly do not serve a purpose within communities. These assumptions are manifest in the participant's reporting of negative perceptions of aging. They have heard the elderly described as useless, burdensome, senile, and weak. There are few articles that look at the perception of aging and the elderly from the perspective of young people. In Nigeria, researchers found that students in health professions knew little about the process of aging and that many viewed the elderly as a burden, even as they were nursing them in the health system. Many of the students had come from rural areas to study and other then interactions with elderly family back home, their only face-time with elderly persons was within the hospital. These hospitalized elderly patients were often the most sick and the authors reported that many of these students nursed the elderly unenthusiastically (B. R. Fajemilehin, 2004).

While this study pertained only to students in health professions, it mirrors the path of many Nigerian young people who move to the city seeking opportunity. For most, these journeys are well-intentioned – in order to provide parents with good return on investment, children must secure jobs,

which are sparse in rural areas. As far back as 1982, demographer John Caldwell described the implicit exchange that takes place between parent and child (J. Caldwell, 1982). Sociologist Margaret Peil carries this idea forward as she writes in 1991, "it is expected that what is given now (food, school fees) will be repaid as children become adults" (Peil, 1991). Later, Peil writes that a changing social structure has had an impact on the type of assistance children provide for elderly parents, but has not changed the social norm of care reciprocation, saying, "it is a burden that few entirely shirk" (Peil, 1991). Jumping forward to 2005, researchers from the University of Nigeria surveyed urban youth and found that the majority do *not* see the elderly as demanding too much from their children (Okoye & Obikeze, 2005). While urban youth report that their elderly person does not demand too much, studies from rural areas tell a slightly different story. A 2012 study conducted in more rural North-Central Nigeria showed that wellbeing among the elderly was poor in the study area. Significant predictors of poor wellbeing included visits by male children only, no financial support from children, and co-habitation with children in households unable to meet their daily needs. In this study, financial strain on the household contributed to an elderly person's poor wellbeing (Adebowale & Atte, 2012). While the 2005 and 2012 studies use different methodologies and take place in different environments, they hint at a disconnect between what is socially desirable and practice, potentially exacerbated by an urban-rural demographic divide. Among the six interviews used for this analysis, four elderly participants had good wellbeing, two had poor wellbeing. One of these elderly participants did not have family support and the other had a leg injury that restricted his mobility.

A shift in attitudes toward the elderly is reflected in the data. At times there is tension between the expectations of the elderly and desires of the youth. As far as the literature is concerned, this tension is undocumented. Participants spoke about this trend with urgency, contrasting the attitudes of youth today with traditional values of respect for the elderly. It should be

noted that none of the young caregiver participants explicitly shared this attitude, however the subtext of the data would indicate that some were not involved in the care of their elderly ones nor did they see them often. In the case of one focus group conducted in an urban setting, participants said that their elderly ones lived in rural areas far away. None of the participants in this group had accompanied an elderly relative to the health center, but reported calling them to "make sure they are fine" or sending money. Because our definition of caregiving included financial provision, these groups were considered caregivers, even though they did not participate in daily care. This discussion was carried out in an urban Muslim community and a similar pattern emerged in the rural Muslim community. In these discussions, it was clear that men provided financial support, while women were direct caregivers. Unfortunately, we were not able to do focus groups with women in Muslim communities and this is a limitation of the data.

Primary Health Care

Perceptions that primary health care (PHC) was inefficient and ineffective were similar across participant groups, although there was some variation among elderly interviewees regarding their perceptions of care. This variation may be a reflection of geographical differences in quality of care provided in PHC facilities. One elderly participant was happy with the service she had received from primary care. This participant lived in a small, tight-knit, rural community. The remaining five interview participants reported going straight to the hospital for care needs, bypassing primary care altogether. Caregivers gave more specifics about how primary care was ineffective and inefficient. If someone were to go to a PHC facility, they would most likely be referred to the hospital because primary care did not have the equipment or trained personnel to treat patients effectively. Going directly to the hospital was more efficient than getting referred from primary care.

Among health professionals, it seemed to be common knowledge that primary health care in rural areas was poor quality. One exception was a doctor from an urban area who had been assigned to work at a rural clinic several days a week. This doctor was lamenting that attendance at the clinic was low because of the belief in the community that primary care was ineffective. To ameliorate this belief, the doctor and his staff conducted house calls to people in the community, including indigent elderly patients. This clinic participated in a World Bank Program called the Nigeria State Health Investment Project (NSHIP) which rewards clinics for increasing patient numbers using a performance-based financing approach. This program is being implemented in Ondo, Adamawa, and Nasarawa states (The World Bank, 2016). The beneficiaries of this program are mostly mothers and children, however, there is a small provision for indigent patients. Among reimbursements that clinics receive for providing care, up to 5 percent may be from indigent patients (Federal Ministry of Health of Nigeria, 2013). The doctor said that the majority of indigent patients he visits as part of this program are elderly. Home-based care for indigent elderly is a model that could expand access to care for neglected older adults, especially those with low mobility.

Interestingly, none of the elderly or caregiver participants spoke about private primary health care. Even within the literature, there is little distinction between private and public PHC in regards to utilization and quality of care. One study did make this distinction by exploring quality of care in a private primary care facility in Rivers State. The authors surveyed patients over a six-month period and found that only about 29% of patients are referred to a hospital or other facility (Ordinioha & Onyenaporo, 2010). The referral rate in public PHC facilities is unknown, but the participants said that it is high. A doctor interviewed in a private PHC facility in Abuja said that cost prevents some from using her services, but she was not asked about referral rate at the facility.

Primary health care utilization is estimated to be around 20 percent (Gupta, Gauri, & Khemani, 2003). Many of the themes emerging in the data have been documented in the literature including untrained staff, variations in rural service delivery, and lack of awareness of the services that primary care does provide (Abdulraheem, Olapipo, & Amodu, 2012). A dearth of primary care services may lead the elderly to seek care elsewhere, either from secondary- or tertiary-level hospitals or from herbalists. According to one study, elderly Nigerians from poor households were more likely to seek health care from unqualified providers than qualified providers (Abdulraheem, 2007). These unqualified providers are often 'native doctors' who specialize in creating healing herbal concoctions.

Native Medicines

All of the elderly participants interviewed used native medicines alone or as a supplement to 'hospital medicines'. While none of the young caregivers reported using native medicines, they acknowledged them as an option. Some of the elderly considered native medicine safe and effective, others did not. Some experienced side effects and adjusted the herbs in the mixture. Ways to increase the perceived effectiveness and safety of native medicine was to talk with others to learn what concoctions had worked for them, add a different herb, or talk with the herbalist to see if the herbs had been tested before usage. There were two types of native medicine users. The first were those for whom hospital medicine did not work or was too expensive and native medicine was the only option available. The second type of user preferred native medicine and although it did not work all the time, made participants feel better. Conversely, one primary care doctor believed native medicines were unsafe. He reported that elderly patients come to him after trying native medicines, delaying care. This doctor also believed that native medicines worsened the condition of some patients. Despite obvious safety concerns, caregivers noted that their elderly ones appreciate the service provided by herbalists because "they find comfort there". Clients are seen quickly, and are

not expected to pay up front. While native medicine certainly has drawbacks, the formal health system could benefit from the 'customer service' model of care.

Use of native medicines is common for all demographic groups in Nigeria. A survey conducted in Lagos found that almost two-thirds of respondents used native medicines. Primary reasons for using medicines were to treat malaria and to lower blood sugar levels. Friends and relatives were reported as the most influential when deciding to use native medicines, a finding consistent with our data. The majority of survey respondents believed herbal medicine was safe because of its natural origin. Far fewer believed herbal medicines were effective, with over half saying that medicines were ineffective or that they were unsure. Over half had experienced adverse effects after using herbal medicine (Oreagba, Oshikoya, & Amachree, 2011). Several elderly participants reported adverse effects from native medicine, including one who was feeling dizzy prior to the interview. These participants said that the side effects do not deter them from using native medicine.

Another study from Lagos University Teaching Hospital found that around 40 percent of their hypertensive patients use herbal medicine in addition to hospital medicines. The most common remedies were garlic, ginger, bitter leaf, and aloe vera. The authors note that although these herbal remedies are relatively benign, they can influence the effects of prescription drugs and have not been evaluated for their effectiveness (Amira & Okubadejo, 2007). In both of these studies, neither education level nor socioeconomic status were predictors of herbal medicine use. We did not collect education or income information from our participants, so it is unclear whether our data supports or refutes this association. However, native medicine use was common among elderly participants, who were purposively selected for educational and income diversity.

Contrary to the findings in our data, the literature suggests that doctors believe that native medicines can be helpful for patients. Over 60 percent of doctors in one study believed that herbal remedies were safe for consumption, but no respondents said that herbal medicine alone was sufficient to treat a patient (Awodele, Agbaje, Abiola, Awodele, & Dolapo, 2012). Among the elderly participants in our study, the majority used only native medicines for treatment. The findings above were part of a two-part study investigating the feasibility of integrating herbal medicine into the formal health care system.

Secondary- and Tertiary-level Hospitals

In our data, the majority of elderly interact with the formal health care system at secondary- and tertiary- level public hospitals. The main barrier to service cited by the elderly and their caregivers was cost. The elderly described the high cost of care in a fatalistic sense. Once a person reaches a certain age, the pathway to death is the same: sickness, inaccessibility of care, decline, and death. Travel over long distances to get to hospitals was difficult for some participants, especially those living in rural areas. For those with lower mobility, either a family member would take them to the hospital or they would stay home. Caregivers also noted the high cost of care, but in the sense that paying for an elderly person puts strain on the family. This 'belt-tightening' was mitigated in some cases by financial support from extended family or the participant's church contributing funds. In Muslim communities, there were no accounts of mosques taking up collections for those in need, although one participant cited the pillar of charity in Islam, or giving directly to the poor. In essence, both Muslim and Christian congregations support those in need, but through different mechanisms. Health providers acknowledged that health care in Nigeria was expensive. The two doctors interviewed in private clinics volunteered that some patients found their prices prohibitive. In that case, patients were directed to public or teaching hospitals.

In a study of health-seeking behavior among the elderly in Nigeria, poverty was reported as the primary determinant of deciding when and where to seek care (Abdulraheem, 2007). But in a later study, income level was not an influencer on private or public hospital choice. In this same study, increasing age was associated with demand for hospital services, but not for clinic services (Amaghionyeodiwe, 2008). This finding is consistent with elderly participant's reporting of going directly to the hospital for health care, rather than a PHC facility. Lastly, private facilities are perceived to be higher quality, despite higher costs (Polsa, Spens, Soneye, & Antai, 2011). High costs in the formal health system may be linked to use of native medicines. In the primary health care system, inefficiency contributes to use of native medicines because effective treatment may require a referral to higher-level, pricier institutions. At the secondary and tertiary level, high costs of services and medication contribute to use of native medicine.

Informal Care

Informal care by family was among the highest quality care that the elderly receive. Elderly participants with income-generating children were grateful they were well taken care of. Those that did not have income-generating children said they had difficulties meeting their basic needs. Elderly participants reported community stigma against families that did not care for their elderly ones, a phenomenon undocumented in the literature.

Caregivers provided accounts of how they care for their elderly one throughout the course of the day. Caregiving may involve multiple siblings or generations. In Christian communities direct care was provided mostly by women, although there were some reports that the elderly person could choose who they preferred as caregiver. In Muslim communities, direct caregivers were always women. Primary caregivers are most likely to be daughters or daughters-in-law and over 98 percent have a positive attitude regarding the care they provide (Abdulraheem, 2005). As older persons

become more dependent, quality of informal care decreases, especially for those with cognitive impairment. Rural-urban migration, decreasing fertility rates, and increasing education for girls are cited as potential contributors to future declines in quality of care at the household level (Uwakwe et al., 2009). Health professionals, policy makers, and village chiefs were quick to talk about the decline in informal quality of care. This decline has led to an increase in indigent elderly individuals, who were described by these participants as "abandoned".

Abuse and Neglect

Health professionals, policymakers and village chiefs had the most to say about elder abuse, possibly because they are able to see the issue from a big picture standpoint. These groups placed the blame for neglect squarely on the shoulders of the youth. Many young caregivers interviewed spoke in detail about the patient-centered care they provide for their elderly ones. Among these caregiver discussions, two were conducted in Muslim neighborhoods with only male participants. These two groups were far less engaged in care than other focus groups, even those that were all-male in non-Muslim communities. During one of these discussions, caregivers were asked what the most difficult part of providing care was:

> R1: …what they need at that age is to give them food. That's what they want. Just give them food and they will be thanking you, showering grace on you, gracing you, all these things. That's what they want now. They don't need all…
>
> I1: So all they need is food?
>
> R1: Yes. You give them food, you give them clothes. *(Caregivers, rural community)*

Other focus groups of male and mixed gender participants spoke of caregiving as an act of love, as providing company and conversation, as making sacrifices to ensure that their elderly one felt happy.

Overall, there was a noticeable difference in attitudes between groups and individuals who were enmeshed in day-to-day care and those that were not.

According to the data, neglect or abuse is a result of various determinants: seldom-visiting or absent children, high level of care needed, poverty, and a negative attitude toward the elderly. While we had not anticipated this theme to be so pervasive, elder abuse in Nigeria is well-documented. While prevalence is unknown, the most common forms of abuse are financial, emotional, and physical. It is important to note that financial abuse in these studies was defined as a deliberate manipulation of an elderly person's finances, rather than financial neglect. A study conducted in Akwa Ibom State mentioned that within families, troublesome older adults may be called witches or wizards, and thrown out of the house. Witchcraft makes an appearance once in the data, as a young man says of the elderly, "And they may be bad people too. Try to join at least this witchcraft. Normally all this – doing sacrifice." Determinants of abuse according to this study were similar to those found in the data, with the addition of intergenerational cycles of violence and personality disorders of caregivers. It was unclear whether this author was alluding to mental health in general, or indeed meant personality disorders (Akpan & Umobong, 2013).

One researcher at the University of Ibadan has conducted extensive research on elder abuse. Eniola Cadmus' 2014 qualitative study analyzed perceptions of elder abuse among older adults in Oyo State. Interestingly, caregiver neglect was not cited as a form of abuse the elderly participants had experienced. None of the elderly participants in our study self-identified as 'abandoned' or 'neglected'. However, elderly participants were quick to point out that many in their community were not well looked after. Participants in Cadmus' study named other atypical forms of abuse such as name-calling, disrespect, and lack of recognition. Determinants of abuse in her study were widowhood, financial dependence, and low physical or mental capacity. Among female elderly

participants, emotional abuse was perpetrated mostly by daughters-in law. The elderly were accused of witchcraft and were restricted access to children and grandchildren. Disrespect of the elderly by the youth was blamed on individualism caused by Western-style education. Among elderly men, financial abuse was more common. Many were supporting unemployed children and became ostracized when they decided to stop providing financial assistance (Cadmus, Owoaje, & Akinyemi, 2015).

More research needs to be conducted to understand the mechanisms of abuse and neglect of the elderly in Nigeria. Risk factors are known, but we need to better understand the initiating drivers of the process of neglect and abuse. One state government official believes that providing 'elderly homes' will mitigate household neglect. According to this official, families could place elderly with high levels of care in these institutions and be assured that they will be well looked after. While institutionalization was seen as solution for some, for others, institutionalizing an elderly one was seen as a failing on the part of the child to provide care. According to an official in the Ministry of Women's Affairs and Social Development, there are 25 long-term eldercare facilities in Nigeria. The study team was able to visit one of these facilities in Enugu State. It was run by a Catholic order and was well-managed. Residents were engaged in a singing activity when we arrived. This facility had a capacity of about 60 residents and a waiting list of 60 people. They took only the most indigent of patients and rejected people from the waiting list on a daily basis. While institutionalization was stigmatized across participant groups, it could provide a safety net for those who are in most dire need of care.

Limitations

This study has several limitations. Firstly, we had hoped to have relatively equal numbers of male and female participants. As discussed previously, male and female participants experience aging

and caregiving differently. More female participants would have improved the diversity of our data. Higher male participation may be attributable to traditional gender norms. With our convenience sample, men were more accessible because they were often seated outside, chatting. Women were more likely to be within the home or family compound and seeking to recruit them may have been construed as an intrusion of inappropriate. Because females were often primary caregivers, we obtained less data on the day-to-day care provided to elderly participants. Future researchers may want to consider conducting FGDs with elderly women and men separately. Caregiver group discussions were more likely to be mixed-gender, except in Muslim communities. Consequently, these data may not speak to the aging and caregiving experiences of Muslim females. Despite this limitation, the data remain valid because although gender is an important factor of aging and eldercare, it was not central to the research question.

We also wanted a diversity of ages of caregivers, but conducted focus groups with people mostly in their 20s and 30s. Because we recruited using convenience sampling, these youth were more likely to be unemployed and home during the day, rather than older caregivers who were at work or away from home during the day. Another limitation regarding recruitment was that numerical age cutoffs were unhelpful in determining eligibility to participate. Many elderly did not know their numerical age. Conceptually, age is more of a status bestowed on someone who is experienced and wise. Numbers do not enter into this determination.

Language barriers were also a significant challenge. In a rural village of a few hundred people, many different dialects may be spoken. In this case, we trained fluent interviewers on the interview guide in the predominant language of the community. Within focus groups, these interviewers encountered participants who did not speak the predominant language of the community. These participants spoke through a gatekeeper. The completed discussions were

transcribed directly to English. There is potential that some data may have been lost in translation. The youth and change-maker discussions took place in English. Considering this, data from elderly participants was lower quality than the two other participant groups. Future research should focus on a more narrowly defined group of elderly participants who speak the same language. Two-step transcription would improve the quality of the data greatly. In addition, more research should be conducted in the northern region of the country, as most of the scholarship on eldercare originates from the South.

Our Lady of Perpetual Help, Home for the Elderly, Enugu State. Photo by the author

Conclusions

Recommendations

Based on the results of this project, we make the following recommendations:

(Recommendations are listed in priority order within groups.)

For donors and funders of health systems strengthening projects

- Expand performance-based financing of primary care that includes care for the indigent or elderly (like the Nigeria State Health Investment Project – see PHC section in Discussion).
- Invest in private home-health care agencies or devise mechanism to subsidize costs for families who need in-home care

For researchers

- Initiate cross-sectional survey research on prevalence of abuse and neglect among the elderly to better understand scope of the issue
- Investigate reasons for primary health care (PHC) under-utilization to examine how to better serve patients
    - Interview PHC facility staff (CHEWs) and conduct focus groups with communities to understand reasons for under-utilization from provider and patient perspectives – should focus on rural areas because need is greater
    - Conduct a needs assessment in a community to highlight the difference between current and desired conditions

    - Meet with health professionals (doctors, nurses, hospital administrators, CHEWs) in private and public facilities at all levels of care to generate ideas for increasing capacity of PHC to meet needs identified by communities
- Increase research focus on:
    - Northern, predominantly Muslim regions of Nigeria
    - Women's experiences of aging and caregiving
- Conduct formative research on:
    - Need, stigma, and feasibility of long-term care facilities as an option for the most indigent elderly
    - Sources of tension between the youth and older generations and effects of this tension on care reciprocation
    - Community stigma as motivation to provide better care and/or as exacerbating poor care
    - Opportunities for synergizing formal health system with native medicines to provide effective, affordable, and patient-centered treatment options (see 'Native Medicine' section in Discussion for ongoing work in this area).

For NGOs

- Create informal caregiver support groups where communities can increase social capital to promote collective care of the elderly and access resources on nutrition and home health care.

Implications

This research has served to support much of the existing literature on aging in sub-Saharan Africa. Many participants spoke about care reciprocation, or the "parent-child contract" in which parents invest in their children expecting the investment to be returned in the form of financial or

caregiving support in older age (Fapohunda & Todaro, 1988). This research also echoes findings that elder abuse and neglect is common in Nigeria, although precisely how common is unknown (Akpan & Umobong, 2013). This, and the role of native medicines in care, originated from the data itself. Upon further exploration of the literature, both abuse and use of native medicines are documented in Nigerian scholarly research.

In sum, PHC is perceived to be inefficient and ineffective and secondary and tertiary care is perceived to be inaccessible. There were many differences in opinion on whether native medicines were safe or effective and further research should not only flush out these perceptions, but also determine whether native medicines are scientifically safe and effective. Despite these doubts, native medicine was seen as potentially patient-centered, following more of a customer service model. However, not enough participants discussed native medicine as patient-centered for it to be coded as such. Lastly, informal care was highly patient-centered, but lack of informal care altogether presents as abuse and neglect of the elderly person.

This research has also documented new findings. The first, more pervasive finding is a tension between older and younger generations. Participants reported that older civil servants delay retirement preventing new graduates from obtaining jobs in the government. Some accuse older adults of being witches or wizards. While accusations of witchcraft toward older people appear in the literature, this tension does not. It is unclear whether this is a new phenomenon, but elderly participants and community leaders assert that this is an alarming trend. Reasons for this tension are unknown and further research should be conducted to determine if this tension indeed exists, what are its sources, and how demographic and macroeconomic forces are fueling this tension. In some cases, the tension was expressed explicitly by young people. In other cases, older adults speculated on why youth were increasingly absent, citing migration to the city as the primary reason.

Community leaders and policymakers placed blame for high levels of neglect squarely on the youth. It seems this sense of tension flows from the older generation to the youth, as well as in reverse.

The second new finding was the influence of community stigma on quality of family caregiving. This stigma served to motivate families to provide better care as well as exacerbating already poor care. In one case, an elderly woman who lived alone and was not being cared for (family was going against the norm of care reciprocation), was derided by members of her community. The community believed that this woman had done something wrong, that's why her children were not caring for her. Conversely, stigma was also reported as providing an impetus for better care for the elderly. A change-maker described the process of 'community sanctioning' in which the community will call a family names or create an unkind song about them in an effort to make them feel guilty for not caring for their elderly person. The change-maker said that sometimes this "gingers them to try and do the best they can".

The first new finding should be explored further as increasing tension could lead to further breakdowns in quality of care for the elderly. Community stigma may be explored as potential exacerbator of neglect of the elderly. Using stigma as a way to push families to take better care of their elderly may not be appropriate, but understanding how stigma operates in the context of informal caregiving will add nuance to this under-researched facet of the health system.

Final Thoughts

While global aging has been the subject of much demographic research, the majority of existing literature documents aging in contexts other than Africa. Demographers note that population aging has yet to take place in sub-Saharan Africa and there is disagreement about when the demographic transition will occur, if at all (He et al., 2016). Research on aging in Africa may not yet be a priority, because of many competing causes for government attention and donor funding.

For the majority of families who want to provide high-quality care for their elderly, cost places care well out of reach. Primary care is largely ineffective, public hospitals are too crowded, and private hospitals are too expensive. Families do their best to provide compassionate care, but their efforts are often tempered by economics. As this research was being conducted, Nigeria was in the midst of an economic downturn. Falling crude oil prices had halted the country's years of consistent economic growth (Doya, 2017). While the economic impact of this downturn on eldercare is beyond the scope of this paper, tightening household budgets were reflected in the data.

While we often label the elderly as 'vulnerable', it is also important to keep in mind our assumptions about what older adults are capable of. Within this data, the elderly were portrayed as weak or infant-like – old age was described as returning to a child-like state, complete with whining, complaining, and constant demand for food. According to some practitioners, elderly with high levels of care should be treated mindfully because they are 'like babies'. In order to create sustainable programming, attitudinal shifts must occur that emphasize individual personhood of older adults and move away from infantilization as justification for better care.

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