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Factors Influencing the Quality of Family-Based Care among Older Adults in Nigeria

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Abstract

The nature of older adults necessitated that they receive quality care. Some of them may have some physical impairments or motor disabilities, which will require them to need help and care. The present study investigated the factors influencing the quality of family based care among older adults in Delta State, Nigeria. Cross-sectional survey design was adopted for the study. The respondents were 1107 older adults. 12 respondents (comprising of 2older adults and 2 caregivers) was selected from each of the 3 Local Government Areas(LGAs) for In-depth interview [IDI]. Forty-eight respondents made up of 24 caregivers and 24 older adults were purposively selected for Focus Group Discussion [FGD], from the three LGAs. This implies 16 (8 caregivers and 8 older adults from each LGA. Thus, the total sample size for the study was 1167 respondents. Majority (72.7%) of the respondents indicated that it was cultural to take care of older adults within the family. Distribution along lines of place of residence revealed that 71.5% were urban residents, 68.8% were semi-urban residents and 77.6% were rural residents. Out of the respondents who indicated that it cost them exorbitantly to take care of older adults, 47.0% were lower income earners while 24.8% were higher income earners. It is cultural to take care of older adults and this is because at a point in time when the caregiver was young the now older adult was the career of the younger person. Place of residence studied were urban and rural dwellers. Some of the older adults were on pension. The study has proved that Family Based Care for older adults has prospects in Ndokwa area of Delta Stat, Nigeria. It was recommended that Local government authorities should provide remuneration and incentives for caregivers and care receivers irrespective of residence.

Keywords: *Social services, special needs, family based care, older adults.*

I. INTRODUCTION

Each individual in every facet of life requires special need, attention and care to perform to maximum ability. The special needs of older adults in the society are the focus of this study. In traditional Nigerian society, it is cultural that family members should be the most natural and conducive social organization for the care and support of older adults, especially the wife, sons, daughters, sons in law, daughters in law. The culture of care in the African context takes a returned gesture paradigm (Ola & Olalekan, 2012). It is expected that older adults who have adequately cared for the younger ones in their young years should in turn take care of them in their old age. Hence, when such care is not being received by these younger ones, they may tend to neglect older adults in

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their times of frailty. Ottong, Bassey and Bassey (2012) observed that a tradition obtainable in Africa is that wicked parents who maltreated their children are likely to be neglected at old age. Therefore, caregiving comes in form of reciprocity between older adults and those they took care of in their active periods (Oluwabamide & Eghafona, 2012).

Nonetheless, level of income of older adults could equally be a factor that could influence support at old age. Some older adults with a good income could provide for their own care and equally those of their caregivers, which all things being equal, balances the costs of stresses associated with caregiving (Yunusa, 2013). Some well to do older adults could equally go as far as hiring caregivers for themselves, which sometimes is occasioned by their quest for autonomy. This has further raised issues as to if older adults would prefer other forms of care to Family Based Care, especially those who have the wherewithal to afford the costs of paid services involved (Zhang, 2014).

In Nigeria and in other African countries, older adults are known to have the habit of retiring to their rural villages after total withdrawal from active life (Wacker & Roberto, 2008). However, those whose children reside in the urban areas or who have built their fortunes in these urban areas, might take exceptions retiring to their rural villages (Raube, 1992). This has created the need to investigate the relationship between place of residence and Family Based Care for older adults in Nigeria using Ndokwa area in Delta State as study area.

Rural-urban and international migration among the young reduces the availability of physical, emotional and social support for older adults as well (Okumagba, 2011). Most older adults, especially rural dwellers, despite their frail nature still carry out physical duties such as: farming, house chores, fetching water and firewood, to mention but few, since the young ones are unavoidably absent for the purpose of searching for greener pastures (Stacey & Ayers, 2012). It is in this respect that Gesinde, Adekeye & Iruonagbe (2012) opine that the process of urbanization and industrialization, the emphasis on nuclear family and neo local residence have brought about increase in the mobility of younger generations and absolute isolation of older adults from their immediate and extended families. To this end, Family Based Care for older adults is being threatened, which could equally occasion cases of abandonment, total neglect and a wide range of unacceptable consequences threatening successful ageing of older adults (Nixon, 2008).

On economic grounds, growing economic problems in the country coupled with high unemployment, have rendered caregivers in Nigeria financially incapacitated to take care of their aged parents (Uwakwe & Modebe, 2007). In addition, many Nigerian women are taking up paid employment in contrast with the traditional role played by them as keepers of the household in the extended family setting. This instance of changing roles of women in contemporary times, has led to a decrease in the availability of primary caregivers for older adults who are largely females (Igbokwe, Ukwuma & Onugwu, 2013). In our today's society, economic activities are no longer gender sensitive as both males and females strive to be economically satisfied. Caregiving for older adults, places caregivers in precarious situations, as effective caregiving demands a degree of economic stability. This no longer gender discriminatory area has affected the females who now strive to be productive economically and as well shoulder responsibilities of caregiving (Tout, 2009).

To achieve successful ageing for older adults, female caregivers who most often would shoulder such responsibilities, would tend to maintain their caregiving responsibilities, which they are culturally bound to deliver (Duffy & Wong, 2008). This ends up exerting so much stress on them and go a long way to affect the

quality of care for these older adults. This is especially the case in a country having harsh economy with little or no justifiable social securities (Fajemilehin & Odebiyi, 2011). People tend not to be blamed when they make efforts to protect their jobs because so much depend on it, of which financial support for older adults is one among many.

Insufficient income could affect care given to older adults. The pension scheme is supposed to be of assistance to older adults who through such social security can at least provide for their care. The anomalies characterizing the scheme, also pose a challenge. This culminated in Ayodeji (2015) asserting that most African governments have paid little or no attention to the socioeconomic securities of their older adults. Thus, caregivers who are vital to Family Based Care are left with no choice than to work so hard to provide for their older adults, themselves and all other persons who form their responsibilities (Eboiyehi, 2008). All these have resulted in the weakening of the family institution, which has played significant role in the care of older adults, who due to physical disability and poor motor abilities are unable to care for themselves (Okoye, 2013).

Previous studies had been on health and nutritional services for older adults, as well as governmental interventions in Nigeria. It was on this gap and need that the authors investigated the factors influencing the quality of Family Based Care among older adults in Delta State in Nigeria utilising the views of caregivers and care-receivers.

II. METHODOLOGY

Ethical approval

Ethical approval was obtained from Ethical Review Board of the University of Nigeria Teaching Hospital, Ituku Ozara, before commencement of the study. Informed consent was also got from respondents. Participants voluntarily participated.

Study participants

A total of 1107 respondents served as the sample size for questionnaire distribution while 12 respondents(comprising of 2older adults and 2 caregivers) was selected from each of the 3 LGAs for In-depth interview [IDI]. 48 respondents made up of 24 caregivers and 24 older adults was purposively selected for Focus Group Discussion [FGD], from the three LGAs. This implies 16 (8 caregivers and 8 older adults from each LGA. Thus, the total sample size for the study was 1167 respondents. Ndokwa West LGA was allotted the sample size of 465 while Ndokwa East and Ukwuani LGA was allotted the same size of 321 respectively. This made up the 1107 sample size for questionnaire distribution. The sample size for this study was derived statistically using the 1967 Taro Yamene formula. n = $\frac{N}{1+N(e)^2}$

n= sample size; N = Population of the study; e = Error estimate at 3% (0.03); 1 = Constant

$$n = \frac{437{,}260}{1+437{,}260(0.03)^2}$$

$$n = 1107$$

The sample size was considered adequate for the study.

Instruments for data collection

The instruments for data collection were both quantitative and qualitative. The quantitative instruments was questionnaire while qualitative were In-depth interviews (IDI) and Focus Group Discussion (FGD). The questionnaire served as the major instrument for collection of data, which had open and close-ended questions. The IDI and FGD guide contained unstructured questions. This provided the freedom to probe and further stimulate further questions which may not be included in the guide but within the scope of the study.

Participants demographic characteristics were got using demographic questionnaire. The questionnaires were self and other administered. Respondents who decided to fill the questionnaire were allowed but those who could not were objectively guided by the researchers. For In-depth interview and Focus Group Discussion, the researchers moderated the interview and discussion sessions while one of them served as the note taker. The participants were informed and given an appointment schedule prior to the exercise. The venue for the IDI was at their homes while the FGD was conducted at a relatively convenient central location in each of the communities. Participation was based on the consent and willingness of the participants to be part of the study.

Study design

Cross-sectional survey design was adopted for the study. The reason for the research design is to guarantee the observation of a population's cross section at one point in time (Barbie, 2007). Therefore, this research design enabled the researchers to make appropriate inferences and generalizations from studying a sample that is the representative of a population under study.

Study setting

The study was in Ndokwa area of Delta State. Delta state is one of the 36 states of Nigeria. It is in south west part of Nigeria. Ndokwa area is in Delta State. It is made of Ndokwa West, Ndokwa East and Ukwuani Local Government Areas (LGA's). Ndokwa area is a coastal area located at the Delta North Senatorial District and is among the oil producing areas of Delta State. The area shares boundary with other LGAs such as Aniocha South, Oshimili South, Isoko North and Ughelli North. Ukwuani, Ndokwa West and Ndokwa East LGAs of the Ndokwa area accommodate nine, six and nineteen communities respectively. Some of which include: Akoku, Amai, Ebedei, Eziokpor, Ezionum, Umutu, Umu ebu, Utagbe Ogbe, Emu, Ogume, Abbi, Aboh, Ibrede, Akarai, Ashaka, Ase, Okpai, Onyah, Afor, Obikwele, Onogbokor, Igbuku and among others. Of the three LGAs, Ndokwa East has the largest land mass and houses more of the urban population (Nnamah, 2016).

The Ndokwa people are known for their agrarian occupation. They fish, rear livestocks and equally plant crops, especially palm-nuts. The area is home to some oil multinationals and thus have residents of the area as workers in the companies. Some of these companies include Noyem Petroleum, Nigeria Agip Oil Company, Don Ochonogor Palm Oil and among others. Inhabitants also engage in civil service professions.

The Ndokwa people are known for their cultural festivals such as the boat-regalia and new yam festival. Older adults tend to assume roles that imply that they are custodians of cultural and religious values. This is perceived as some form of support for them. Caregiving must have to put into consideration the meanings of these values for older adults.

Ndokwa area of Delta State houses both urban and rural population, which helped in comparing findings. It also accommodates a good number of older adults who retire to their communities upon completion of active employment in the service. This aided the researchers to have a perfect population for the study to sample from, comprising the older adults and their caregivers.

Research procedure

The informed consent of the respondents were obtained. They were assured of confidential handling of their personal information. Each community in Ndokwa West was allotted 155 respondents comprising of 78 older adults and 77 caregivers. While selected communities in Ndokwa East and Ukwuani was allotted respondents comprising of 53 older adults and 54 caregivers. To get to the final respondent bottle spinning method from a particular village square was used to determine the starting point for data collection in the community. The housing units along the selected routes qualified for inclusion. For any housing unit along the selected to be eligible for the study, there must be an older adult and caregiver. For housing unit along the chosen route that does not have an eligible respondent, the researchers moved to the next housing unit. When one route is exhausted without getting the required number, another route was selected to get the required number.

To get to the 60 respondents for the qualitative part of the research, purposive and snowball sampling was used as well. The purposive sampling targeted those who have the needed information for the research (Older adults and caregivers). In addition to that, the snowball sampling aided in referrals to those who are also (older adults and caregivers).The FGD was in groups of two for each of the LGAs. One for older adults and another for caregivers respectively in each of the LGA's. Eight persons of the same sex was present for each of the two FDGs [all older adults and all caregivers] at different times). Each group was made up of either older adults or caregivers in all the three selected LGAs. The IDI took four participants from each of the LGAs. Two older adults and two caregivers was purposively selected from the 3 LGAs making 12 respondents. In addition, care was taken to ensure that each group was homogenous in terms of educational and economic backgrounds.

The respondents were divided into two groups, older adults also known as care receivers and caregivers. Five hundred and fifty-two (552) copies of questionnaire were distributed to older adults. There was a return rate of 97%. On the other hand, five hundred and fifty-five (555) copies of questionnaire were distributed to caregivers and there was a return rate 97%. The high return rate was ensured through greater effort made towards other administered method when compared to self-administered method even though both were employed. The qualitative data collected through Focus Group Discussions (FGD) and In-depth Interviews (IDI) were used to support and elucidate the quantitative data.

Method of data analysis

This study utilized both quantitative and qualitative methods in data analysis. The data from the questionnaire were coded, computer processed and analysed using the Version 20 of the Statistical Package for

the Social Sciences (SPSS). Descriptive statistics such as percentages and frequency tables were used in presenting the results. Linear regression analysis was used to predict the influence of some independent variables (factors) on the dependent variable.

The qualitative data were analysed in themes as complement to the quantitative data. The data was translated into English. From the transcription words and phrases special in the local language was translated into English to ensure that both versions carry same meanings as identified and used in supporting findings from the quantitative method.

III. RESULTS

Table 1: *Distribution of respondents by socio-demographic characteristics (Care receiver) and place of residence*

Socio-demographic variables	Place of residence			Total
	Urban	Semi-Urban	Rural	
Gender				
Male	92(54.1)	78(44.6)	96(49.5)	266(49.4)
Female	78(45.9)	97(55.4)	98(50.5)	273(50.6)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**
Age				
60 - 70years	86(50.6)	107(61.1)	101(52.1)	294(54.5)
71 - 81year	49(28.8)	42(24.0)	64(33.0)	155(28.8)
81 - 91year	28(16.5)	22(12.6)	20(10.3)	70(13.0)
91 years and above	7(4.1)	4(2.3)	9(4.6)	20(3.7)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**
Marital Status				
Single	1(0.6)	0(0.0)	1(0.5)	2(0.4)
Married	99(58.2)	115(65.7)	122(62.9)	336(62.3)
Separated	19(11.2)	15(8.6)	16(8.2)	50(9.3)
Divorced	5(2.9)	8(4.6)	7(3.6)	20(3.7)
Widowed	46(27.1)	37(21.1)	48(24.7)	131(24.3)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**
Occupation				
Civil servant	46(27.1)	39(22.3)	17(8.8)	102(18.9)
Trading	35(20.6)	24(13.7)	44(22.7)	103(19.1)
Self-employed	45(26.5)	61(34.9)	43(22.2)	149(27.6)
farming	39(22.9)	43(24.6)	71(36.6)	153(28.4)
Fish trader	5(2.9)	8(4.6)	19(9.8)	32(5.9)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**
Educational Qualification				
No formal education	27(15.9)	17(9.7)	43(22.2)	87(16.1)
Primary education	39(22.9)	24(13.7)	58(29.9)	121(22.4)
Secondary education	53(31.2)	75(42.9)	64(33.0)	192(35.6)
Tertiary education	51(30.0)	59(33.7)	29(14.9)	139(25.8)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**
Religion				
Christianity	146(85.9)	162(92.6)	168(86.6)	476(88.3)
Islam	3(1.8)	2(1.1)	3(1.5)	8(1.5)
African traditional religion	21(12.4)	11(6.3)	23(11.9)	55(10.2)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**
Monthly income				
No income	17(10.0)	15(8.6)	41(21.1)	73(13.5)
#100.00 -#18,000	48(28.2)	52(29.7)	76(39.2)	176(32.7)
#19,000 - #48,000	52(30.6)	47(26.9)	45(23.2)	144(26.7)
#49,000 -#78,000	34(20.0)	33(18.9)	19(9.8)	86(16.0)
#79,000 -#108,000	7(4.1)	13(7.4)	10(5.2)	30(5.6)
#109,000 -#138,000	11(6.5)	15(8.6)	3(1.5)	29(5.4)
#139,000 and above	1(0.6)	0(0.0)	0(0.0)	1(0.2)
Total	**170(100.0)**	**175(100.0)**	**194(100.0)**	**539(100.0)**

Research questions

The following research questions were

Table 2: *Distribution of respondents by whether it was cultural to take care of older adults within the family and place of residence (caregivers)*

Views on cultural obligation to care	Place of residence			Total
	Urban	Semi-urban	Rural	
Yes	93(71.5)	128(68.8)	142(77.6)	363(72.7)
No	19(14.6)	22(11.8)	16(8.7)	57(11.4)
No idea	18(13.8)	36(19.4)	25(13.7)	79(15.8)
Total	130(100.0)	186(100.0)	183(100.0)	499(100.0)

Table 2 indicated that majority (72.7%) of the respondents indicated that it was cultural to take care of older adults within the family. Distribution along lines of place of residence revealed that 71.5% were urban residents, 68.8% were semi-urban residents and 77.6% were rural residents. On the other hand, a smaller proportion (11.4%) of the respondents who indicated that it was not cultural to take care of older adults within the family had with 14.6% as urban residents, 11.8% semi-urban residents and 8.7% rural residents. Another proportion (15.8%), indicated that they had no idea whether it was cultural to take care of older adults in their community. Among them, 13.8% were urban residents, 19.4% were semi-urban residents and 13.7% were rural residents.

It could equally be observed from the distribution that more rural residents (77.6%) than urban or semi-urban residents indicated that taking care of the elderly within the family is cultural. This was because cultural practices are usually prevalent in rural areas when compared to urban areas where indigenous values has been eroded by globalization. In comparison with data from the distribution of views of older adults, a greater proportion of semi-urban dwellers (92.0%) were of the view that it was cultural to take care of older adults within the family when compared to urban and rural residents respectively.

Views from participants of the FGD and IDI further elucidates this finding. One of the participants in an FGD opined that, “It is our culture because you can’t take your mother to old people’s home...” **(FGD: Female caregiver).**

In an IDI session, a female respondent opined that:

It is cultural for me to take care of my older adult mother. I also expect that at my old age my own daughter will also do same for me. It is cultural that we must take care of older people in the family because she is my mother and you know your turn will come and you can’t reject her but to free yourself of that burden. There is no other way so you must do it” **(IDI: Female caregiver).**

In another IDI session, a female caregiver also indicated that it was cultural and a traditional value to take care of an older adult in Ndokwa:

Yes it is a cultural to take care of elderly one like we have “umunna” (kinsmen) whatever you have, if its fish you will give it to the elderly one, then if you have yam you give it to the elderly one. Therefore, we do it during harvest period like fish, cassava and yam any foodstuff it is tradition and you must do it **(IDI: female caregiver).**

Table 3: *Distribution of respondents by reason for their answer on whether it was cultural to take care of older adults within the family (caregivers)*

Why it is cultural obligation to care	Frequency	Percent
It is traditional	363	86.4
no law to that effect	57	13.6
Total	**420**	**100.0**

Table 3 indicated that majority (86.4%) of the respondents were of the view that traditionally a cultural obligation to care for older adults and 13.6% were of the opinion that there is no law to that effect, hence not a cultural obligation.

Table 4: *Distribution of respondents by how people of Adowa treat older adults and place of residence (caregivers)*

Views on treatment of older adults	Place of residence			Total
	Urban	Semi-urban	Rural	
Well and good	91(70.0)	122(65.6)	137(74.9)	350(70.1)
Poorly	31(23.8)	52(28.0)	40(21.9)	123(24.6)
No idea	8(6.2)	12(6.5)	6(3.3)	26(5.2)
Total	130(100.0)	186(100.0)	183(100.0)	499(100.0)

Table 4 revealed that a higher proportion of rural residents (74.1%) treat their older adults well and good followed by urban residents 70.0% and semi-urban residents 65.6%. On the other hand, greater proportion of semi-urban dwellers 28.0% were of the view that people of Adowa community treat elderly persons poorly, followed by urban residents (23.8%) and rural residents (21.9%) respectively. Furthermore, among those who had no idea about how Adowa people treat older adults had a higher proportion (6.5%) among semi-rural residents, 6.2% among urban residents and 3.3% among rural residents. In total, majority of the respondents (70.1%) were of the opinion that they are treated well and good, another proportion (24.6%) were of the view that they are treated poorly. Only a small percentage (5.2%) indicated no idea.

Views of a participant in an FGD throws more light on this as the participant opined:

Our people take care of older adults very well. Before my mother died, I give her enough care and money for her feeding because she suffered to take care of me and after taking care of me and aged I am the one

to take care of her. Like now, my children are the ones to be taking care of me, anyone that that has money will give me for my feeding until the day of my death. **(FGD: Older adult).**

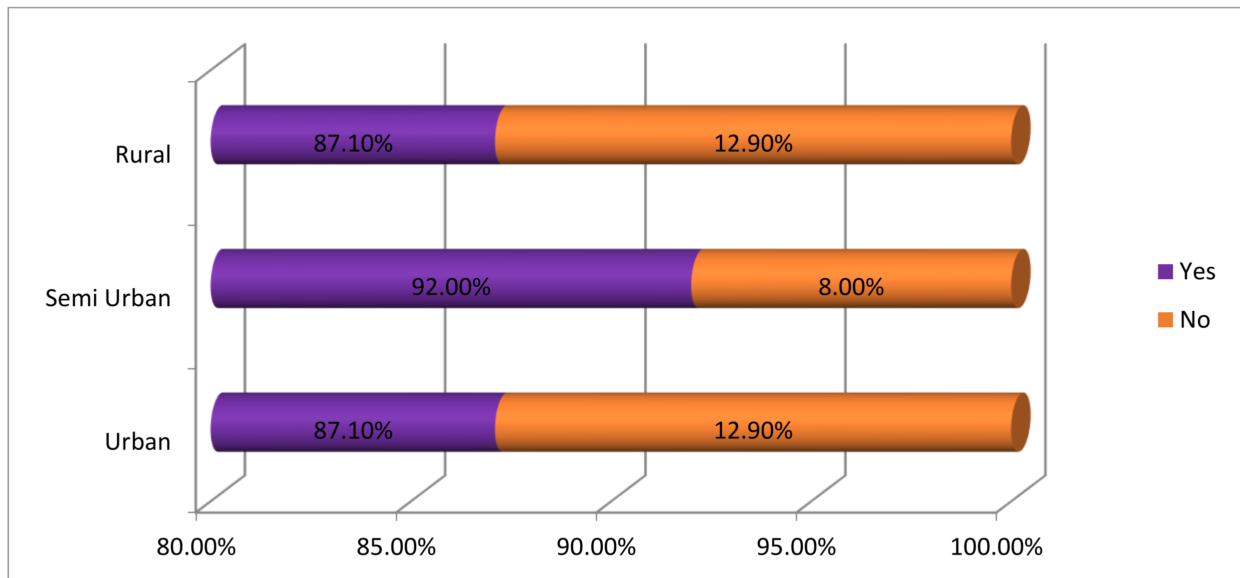

Figure 1: *Distribution of respondents on cultural care of older adults in their home and place of residents (Care receiver)*

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Figure 1 shows that a greater proportion of the older adults believe that it is cultural to take care of older adults within the home with 87.1%% residing in urban areas, 92.0% residing in semi-urban areas while 87.1%% reside in rural areas. On the other hand, lesser proportion of the older adults were of the view that it is not cultural to take care of older adults within the family with 12.9% dwelling in urban areas, 8.0% in semi-urban areas while 12.9% live in rural areas. These distributions show that greater proportions of semi-urban residents (92.0%) were of the view that it is cultural to take care of older adults within the family when compared to urban and rural residents respectively.

This section examined the factors related to economic aspects of caregiving and care receiving.

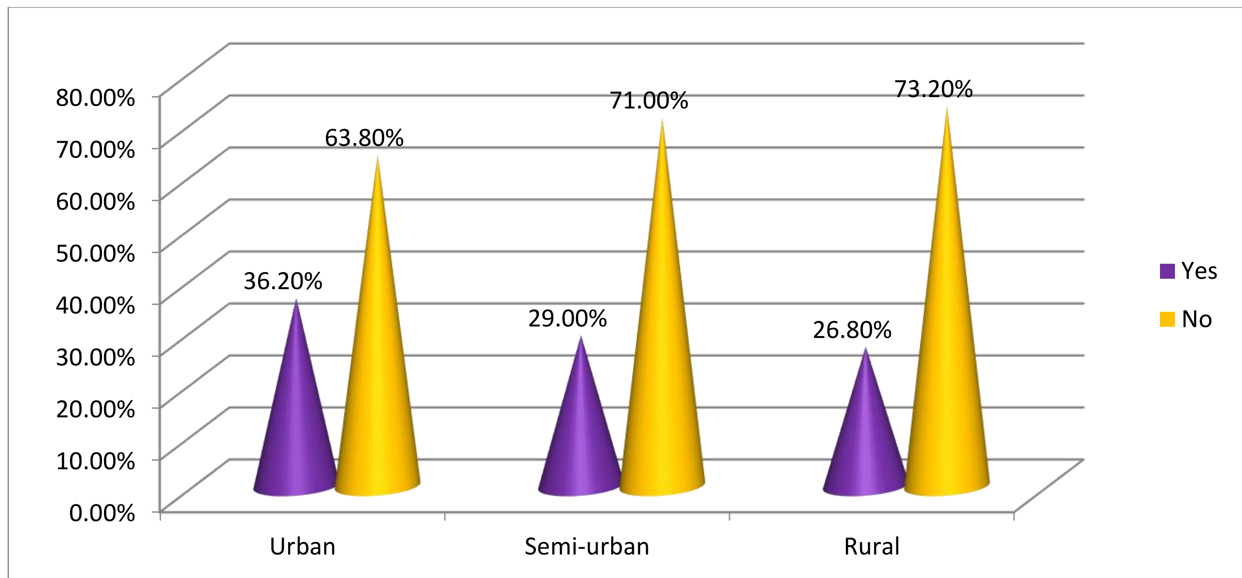

Figure 2: *Distribution of respondents by whether they are on any stipend for caring for the older adult and place of residents (caregivers)*

Figure 2 showed that majority of rural residents (73.2%) indicated that they were not on stipend for caring for older adults, followed by 71.0% of semi-urban residents and 63.8% of urban residents. On the other hand, out of those who indicated that they receive stipend for caring for their older adults 36.2% were urban residents, 29.0% were semi-urban resident while 26.8% were rural residents. It can be observed that greater proportion of the respondents who were of the view that they are not given stipend for caring for their older adults were rural residents (73.2%). Furthermore, in comparison of external support for both caregivers and care receivers. It was observed that greater proportions of caregivers do not receive stipend for caring for older adults.

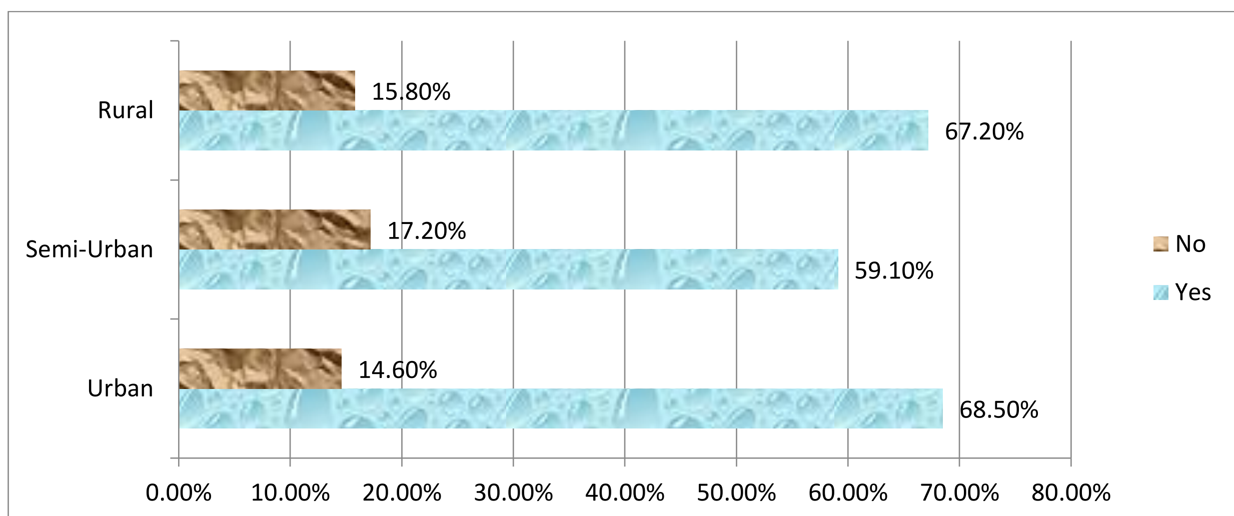

Figure 3. Distribution of respondents on whether they are on pension and place of residence (care receiver).

The result from an IDI session revealed that some older adults in urban areas are on pension. According to a participant, discussant who is a retired legal practitioner, “Income I receive since my pension began as a

retired legal practitioner is okay for my upkeep. Without the pension it would have being difficult because I do not want to put financial burden on my children" **(IDI: Older adult and a retired legal practitioner).**

Table 5: *Distribution of respondents by rating of the cost of taking care of older adult in a month and place of residents (caregivers)*

Cost of taking care of older adults	Income Level		Total
	Lower Income	Higher Income	
Exorbitantly	185(47.0)	26(24.8)	211(42.3)
Moderately	209(53.0)	79(75.2)	288(57.7)
Total	394(100.0)	105(100.0)	499(100.0)

Table 5 shows that out of the respondents who indicated that it cost them exorbitantly to take care of older adults, 47.0% were lower income earners while 24.8% were higher income earners. On the other hand, out of the respondents who indicated that it cost them moderately to take care of their older adults, 53.0% were lower income earners while 75.2% were higher income earners. The distribution revealed that majority of the higher income earners (75.2%) were of the view that it cost them moderately to take care of their older adults.

Table 6: *Distribution of respondents by the support they received from relatives for caring for the older adults (caregivers).*

Received support for caring for older adults	Frequency	Percent
Financial	187	37.5
Emotional	174	34.9
Religious	63	12.6
Can't say	75	15.0
Total	499	100.0

Table 6 shows that 37.5% of the caregivers noted that they receive financial support from relatives for caring for older adults, 34.9% indicated that they receive emotional support from relatives for caring for older adults, 12.6% receive religious support while 15% cannot say if they receive social support. It can be observed that greater proportion of the care givers (37.5%) were of the view that they receive financial support from relatives for caring for older adults.

Table 7: *Distribution of respondents by whether the money they have is enough to take care of older adult and place of residence (caregivers)*

Views on having enough to care for older adults	Place of residence			Total
	Urban	Semi-urban	Rural	
es	45(34.6%)	74(39.8%)	58(31.7%)	177(35.5%)
o	85(65.4%)	112(60.2%)	125(68.3%)	322(64.5%)
Total	130(100.0%)	186(100.0%)	183(100.0%)	499(100.0%)

Table 7 shows that 35.5% of the caregivers indicated that the money they have is enough to take care of older adults 34.6% were urban residents, 39.8% were semi-urban residents while 31.7% were rural residents. On the other hand, among the care 64.5% who indicated that the money they have is not enough to take care of their older adults 65.4% were urban residents, 60.2% were semi-urban residents while 68.3% were rural residents. It can be observed that greater proportion of those who indicated that the money they have is not enough to take care of their older adults were rural residents (68.3%).

Table 8: *Distribution of respondents by reason they are not on pension (Care receiver)*

Why they are not on pension	Frequency	Percent
Self employed	361	80.8
Still a serving civil servant	61	13.6
Because am a farmer	18	4.0
Worked in the private sector	7	1.6
Total	**447**	**100.0**

Table 8 revealed reasons why the older adults are not on pension. Majority (80.8%) gave they view that they are self-employed, followed by 13.1% who indicated that they are still in service, 4.0% indicated that they are farmers and 1.6% worked in the private sector.

Table 9: *Distribution of respondents by their major source of income and place of residence (Care receiver)*

Source of income	Place of residence			Total
	Urban	semi urban	Rural	
Savings	79(46.5)	115(65.7)	91(46.9)	285(52.9)
gift from friends	8(4.7)	11(6.3)	9(4.6)	28(5.2)
Children	56(32.9)	27(15.4)	66(34.0)	149(27.6)
gift from friends/ relations	15(8.8)	12(6.9)	14(7.2)	41(7.6)
charity organizations	6(3.5)	7(4.0)	5(2.6)	18(3.3)
can't say	6(3.5)	3(1.7)	9(4.6)	18(3.3)
Total	170(100.0)	175(100.0)	194(100.0)	539(100.0)

Table 9 shows that 52.9% of the older adults agreed that their major source of income was through savings with 46.5% residing in urban areas, 65.7% residing in semi-urban areas while 46.9% reside in rural areas. This was followed by those who indicated that it was from their children (27.6%) with 32.9% residence in urban area, 15.4% residence in semi-urban area while 34.0% dwells in rural areas. Another 7.6% were of the view that their major source of income was gifts from relatives with 8.8% residing in urban areas, 6.9% in semi-urban areas and 7.2% in rural areas. The next proportion 5.2% indicated that their major source of income was gift from friends with 4.7% residing in urban areas, 6.3% in semi-urban areas while 4.6% dwell in rural areas. Small proportions 3.3% indicated that it was from charity organisations or that they cannot say respectively. Those of the view that their major source of income was from charity organizations, had a distribution of 3.5% residing in urban areas, 4.0% semi-urban areas and 2.6% in rural areas. Lastly, those who cannot say where their major source of income comes had a distribution of 4.6% rural residents, 3.5% urban and 1.7% semi-urban residents respectively.

Table 10: *Distribution of respondents by how often caregivers sibling visit and level of income (caregivers)*

How often siblings visit	Level of Income		Total
	Lower Income	Higher Income	
very often	122(31.0)	32(30.5)	154(30.9)
Often	168(42.6)	49(46.7)	217(43.5)
Rarely	104(26.4)	24(22.9)	128(25.7)
Total	394(100.0)	105(100.0)	499(100.0)

Table 10 shows that out of the caregivers who reported that their siblings visit them very often, 31.0% were lower income earners while 30.5% were higher income earners. Again, out of those who indicated that their siblings visit them often 42.6% were lower income earners while 46.7% were higher income earners. On the other hand, for those who said that their siblings rarely visit them 26.4% were lower income earners while 22.9%

were higher income earners. It can be observed that greater proportion of the caregivers who were of the view that their siblings visit them often were higher income earners (46.7%).

Table 11: *Distribution of respondents by the support they receive from their relatives and place of residence (Care receiver)*

Received support from relatives	Place of residence			Total
	Urban	Semi urban	Rural	
Financial	110(64.7)	107(61.1)	123(63.4)	340(63.1)
Emotional	31(18.2)	26(14.9)	25(12.9)	82(15.2)
Religious	15(8.8)	11(6.3)	18(9.3)	44(8.2)
Can't say	14(8.2)	31(17.7)	28(14.4)	73(13.5)
Total	170(100.0)	175(100.0)	194(100.0)	539(100.0)

Table 11 revealed that majority (63.1%) of older adults indicated that they receive financial support from relatives with 64.7% residing in urban areas, 61.1% in semi-urban areas while 63.4% reside in rural areas. Some of the older adults (15.2%) reported that they receive emotional support from relatives, with 18.2% residing in urban areas, 14.9% in semi-urban areas while 12.9% reside in rural areas. In addition, another proportion of 8.2% indicated that they receive religious support from their relative with 8.8% residing in urban areas, 6.3% in semi-urban areas and 9.3% in rural areas. Lastly, 13.5% of the older adults were of the view that they cannot say if they received any support from relatives and had a distribution of 8.2% in urban, 17.7% in semi-urban and 14.4% in rural residents. This distribution shows that greater proportion of urban older adults (64.7%) was of the view that they receive financial support from relatives compared to semi-urban and rural residents respectively.

Table 12: *Regression analysis predicting the influence of socio-demographic variables on preferred form of care for alder adults in Ndokwa area of Delta state by caregiver*

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	1.350	.219		6.174	.000
Place of residence	.007	.026	.015	.286	.775
Gender of care giver	-.036	.040	-.045	-.900	.368
Level of education	-.089	.048	-.106	-1.864	.063
Age	-.009	.019	-.029	-.461	.645

Income	-.033	.058	-.035	-.579	.563
Marital Status	-.011	.052	-.013	-.209	.835
Occupation	-.046	.066	-.040	-.692	.489
Religion	.152	.072	.110	2.122	.034

Table 12 revealed that the independent variables are place of residence (ß= .007; t= .286); gender (ß= -.036; t= -.900); level of education (ß= -.089; t= -1.864); age (ß= -.009; t= -.461); level of income (ß= -.033; t= -.579); marital status (ß= -.011; t= -.209); occupation (ß= -.046; t= -.692); and religious (ß= .152; t= 2.122). These socio-demographic variables were the independent variables while perception on preferred form of caregiving to alder adults is the dependent variable. The result of the regression analysis indicated that only one variable which is religious affiliation (ß= .110; t= 2.122) was statistically significant with a p value of .034. Thus, religious affiliation had influence on caregivers preferred form of caregiving for older adults in Ndokwa area of Delta State.

As a form of comparison, some socio-demographic variables of care receivers were used as independent variables to predict their influence on preferred form of care for older adults as the dependent variable. This is presented on Table 13:

Table 13: *Regression analysis predicting the influence of socio-demographic variables on preference of form of care for older adults by older adults (Care Receivers)*

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	1.192	.162		7.334	.000
Gender	.034	.033	.047	1.031	.303
Marital Status	-.023	.013	-.081	-1.711	.088
Place of residence	.012	.019	.029	.644	.520
Age	-.014	.019	-.032	-.706	.481
Occupation	-.016	.046	-.018	-.351	.725
Education	-.078	.043	-.095	-1.802	.072
Religion	.025	.050	.023	.502	.616
Income	.057	.039	.070	1.463	.144

Table 13 revealed that the independent variables; gender (ß= .034; t= 1.031), marital status (ß= -.023; t= -1.711), place of residence (ß= .012; t= .644), age (ß= -.014; t= -.706), occupation (ß= -.016; t= -.351), level of education (ß= -.078; t= -1.802), religious affiliation (ß= -.025; t= .502), level of income (ß= .057; t= 1.463). Perception on preferred form of caregiving for older adults by older adults is the dependent variable. The result of the regression analysis showed that none of the independent variables was statistically significant at p= 0.05. This also implied that the socio-demographic variables (independent variables) does not influence older adults

preferred form of care in Ndokwa area of Delta State. This also shows that care receivers' view and preference for Family Based Care is independent of demographic influences.

IV. DISCUSSION

The result showed that Caregivers preferred older adults to be taken care of within the family because it was cultural in Ndokwa area of Delta State Nigeria to take care of older adult within the home. Furthermore, it was revealed that caregivers treat older adult well, good and kindly. On the other hand, from the point of view of older adults it was cultural to take care of older adults in Ndokwa within their home. Similar finding was revealed in a study conducted in Ghana by Yiranbon et al (2014). This study revealed that it was cultural to take care of older adult within the home or family. The study further revealed that institutional care was alien to the people's culture and tradition of caregiving.

Furthermore, the study revealed that caregivers do not receive stipend in Ndokwa for caring for older adults. In addition, most of the older adults were not on pension. The reason most of the older adults were not on pension was because they were self-employed, farmers and some worked in private sector, however the few older adults that were on pension were retired civil servants.

The study revealed that the cost of taking care of older adult was moderate, and in some cases, it was exorbitant. However, the higher income earners consider the cost moderate when compared with the lower income earners. It was also revealed that Caregivers do not have enough money to take care of their older adults. The study showed that the sources of income of older adults in Ndokwa were savings, gifts from friends, children, relatives and very few times charity organizations. It was also revealed that older adults receive financial, emotional and religious/ spiritual support from relatives. In the same vein, Okumagba (2011) opined that older adults receive financial and material support from children and relatives.

There is a statistically significant relationship between caregivers place of residence and challenges and problems they face as a result of caring for older adults within the family (P =. 012). Furthermore, There is no statistically significant relationship between caregivers' level of income and preferred form of care for older adults. (P =. 096). This implied that care receivers or older adults face challenges from caregivers irrespective of their level of income. Similarly Chorn-Dunham & Dietz, (2003) were of the view that informal caregiving is often inherently rewarding for those who provide it, but it can also be emotionally, physically, and financially burdensome for caregivers.

The findings of this study are significant in several ways. This research will add to the existing body of knowledge on care for older adults including those with other special needs in the African context, especially in a time of increased modernization and globalization. It will also stimulate further research on Family Based Care or related fields of study.

The research findings will further provide guide for policy formulation for older adults and bring about favourable changes in the already existing policy that is yet to be implemented in our country Nigeria, regarding older adults. The findings will benefit special educators in providing special needs services for older adults and their families. The care needed by each vary and they must be catered for as individuals. Such will go a long way to influence the quality of family based care they can receive.

Strengths and limitations of the study

The findings of this study contributed to our understanding of the factors that can influence the quality of family based care among older adults. They are special people in the society with distinct needs. The study revealed that these factors- culture, place of residence, income among others are pertinent factors that affect the quality of family based care received by older adults in Nigeria.

Notwithstanding the success of this study, it had some limitations. Firstly, the participants demanded for incentives during In-depth interview, (IDI) Focus group discussion (FGD) or questionnaire. The researchers explained the reasons for the study which made respondents happy that their own daughters will soon join the group of doctors in the community. Secondly, some of the older adults are weak and some suffer from dementia which may affect the validity of information in some of the cases. Finally, the period was the rainy season in Nigeria. Constant rainfall adversely affected data collection and collation. To curb this, future studies in the area should be during the dry season.

V. CONCLUSION

The findings of the study show some of the factors that influence the quality of family based care among older adults in Delta State, Nigeria. It is cultural to take care of older adults and this is because at a point in time when the caregiver was young the now older adult was the career of the younger person. This mutual reciprocity made it a tradition and culture in Ndokwa area to care for older adults. Other factors are place of residence and income. Place of residence studied were urban and rural dwellers. Some of the older adults were on pension. The study has proved that Family Based Care for older adults has prospects in Ndokwa area of Delta State, for it is the most preferred form of care available at the time of the study. It was recommended that Local government authorities should provide remuneration and incentives for caregivers irrespective of residence. Also, awareness of old people's home and institutional based care should be created. This would enable older adults who do not have relations that can provide care or those whose children are not disposed to provide care at home to utilize the facilities in an old people's home.

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