Inaugural Lecture Series 221

CARING, HEALTH AND LONGEVITY

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Mr. Vice-Chancellor, the Principal Officers of the University, Provosts, Deans, Academic and Non-Academic Colleagues, Guests, Relations, students, ladies and gentlemen, I was made to understand that traditionally, an inaugural lecture is one of the first responsibilities of a newly promoted University Professor. In it he exercises a singular honour and privilege to formally address the entire University community on a scholarly topic that has occupied his mind and time, as well as some of his hope for the future. This inaugural lecture is the second emanating from the Department of Nursing Science of the College of Health Sciences of this Great University and that, the chair which I have the greatest pleasure and honour to inaugurate this evening is the first to be given by an alumnus of the Department since inception.

Introduction

Growth is both quantitative and qualitative characteristic of all living things man inclusive interacting with the environment and socio-cultural changes. The first goal of Healthy people is to increase the span of a healthy life for every being with emphasis on health not just longevity. The second and third goals are to close the gaps in health status and health outcome and achieve access to preventive services for various age sub groups. Man as a bio-socio-cultural entity, relies on his or her cultural influences to moderate and adjust his beliefs, values and customs as socially defined. Therefore, it also influences man’s entry point into the health care system and determines the uses of such resources for personal health care practices. Care givers (informal or formal) need to be aware of cultural behaviour patterns so as to be able to recognize and understand their clients’ biases, behaviours and beliefs so as to achieve effective interaction. Hence, this lecture intends to examine not only the developmental changes but also the interacting effects of historical changes, health technological advances and the interplay of relationship between one’s state of health, changing needs of man and care services as rapid change continues to transform care giving and the health care system.

Concept of health, disease and health promotion

Concepts of diseases, medical treatment and care, health and health promotion do not exist in a socio-cultural, institutional and political vacuum.
They reflect the values, beliefs, knowledge and practices shared by lay people, professionals and other influential sub groups.

Worldwide, health is defined in negative terms as the absence of disease. According to the socio-medical paradigm, there is clear link between the prevalence of health or ill health in any given population, socio-economic and socio-cultural factors. Progress in medical science and technology over the last 100 years has produced also an immense body of knowledge that allows us specify distinct diseases in ever greater detail, explain their underlying mechanisms and use many forms of intervention to prevent and treat them and minimize distress, suffering and disability. The vast organizational complexes called health care system that exist in many countries have become a source of growing and serious concern, despite their unquestionable contribution to the cure of disease and the care of the sick. However, Health is defined in the WHO constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Describing health is a general value, this definition neither serves as a framework for formulating goals of health policy nor for deriving operational definitions of health. Nevertheless, it has been criticized for several reasons; one being that it conceptualizes health as a normative state, as an ideal goal that can never be attained. Other criticism is that, it is ambiguous in terms of the concept of health itself and the notion of well being since complete well being is difficult to measure. Hence, critics have seen health not as a state but a task, and a means to an end such as the fulfillment of role obligations.

Concepts of health as a process, an activity or a potential are emphasized in the following statements. Thus, health in this lecture is conceived as:

a) a modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence while they cope with an imperfect world;

b) imputed capacity to perform tasks and roles adequately; and

c) the power to live a full, adult-breathing life in close contact with what one loves and wants to be all that one is capable of becoming.
Another perspective saw Health as an activity or potential which emphasized in the parameters that our choices of lifestyle can most affect the way we enjoy health as a way of life resulting in an experience of well being as product of a dynamic balance that involves the physical and the psychological aspects of the organism, as well as its interaction with its natural and social environment. Thus, a socio-ecological paradigm is a suitable framework for explaining the conditions and causes of health and ill health and for guiding health related activities as well as health and social policies. Obviously, such a paradigm will have to integrate the biomedical, the psychosocial and as well as the socio-cultural perspectives (WHO and IEA, 2000).

As most of these concerns are well known, only the main symptoms of what have been referred to as “health crisis 2000” will be mentioned here. In the developed world, these are the growing numbers of “new deaths” due to diseases of the cardiovascular, renal and the respiratory systems, diabetes, cancer and accidents to mention just a few; the increasing prevalence of diseases of lifestyle; the problems of the elderly and the mental illness; the health cost of poverty and unemployment; the health consequences of pollution; specialization and sub-specialization in health care; the growing cost of medical technology; poor planning and unbalanced allocation of health resources; and the uncontrolled rise of health care expenditure in many countries. In the developing world, large proportions of the population suffer from a high prevalence of ill health and die prematurely, a situation that is largely due to a serious shortage of food and poor living conditions.

A new health consciousness among large segments of the population and new health movements can be observed in a growing number of countries. At least in part they seem to reflect concern about the apparent or real health crisis. WHO has launched a global strategy for health for all by the year 2000 (WHO & IEA, 2000), which calls for a reorientation of health policy and health services and for new properties in the distribution of health resources aimed at the promotion of positive health. Regrettably, we recorded a failure due to lack of political will and economic commitment of the various National Governments.
The socio-ecological paradigm of health

Health in change and health sciences are currently witnessing the beginning of a shift from a stage of traditional biomedical science towards a stage where a more global perspective, such as a sociological paradigm, may eventually replace the biological paradigm, ideally by integrating it. A considerable body of scientific research and relevant theory has already been accumulated by more recent disciplines and by multidisciplinary fields that strongly support the psychosocial and ecological perspectives and provide elements for the new paradigm: biomedical epidemiology and community medicine (WHO and IEA, 2000), medical sociology and social epidemiology and psychosomatic medicine. Quite obviously, a shift in medical paradigm, as indicated here, has certain implications for the concepts of health and disease as well as for health protection, promotion and prevention.

According to this system, well being and or ill health is conceived as resulting from an equilibrium or otherwise between environmental factors such as winds, temperature, water, soil and food, and an individual’s way of life, i.e. his or her eating, drinking and sexual habits as well as work and recreational behaviour. This “external” balance between man and his environment was assumed to determine his internal balance, equilibrium between his four humours of the human body: blood, phlegm, black bile and yellow bile. Within this paradigm, clinical practice was meant to assist nature’s healing forces and public health problems by understanding the human ecosystem and put health as a state of balance. Hence, in the biomedical paradigm, disease is seen as a “temporal, or permanent impairment in the functioning of any single component, or of the relationship between components making up the individual” or – more succinctly – “the breakdown of the “machine”, and the doctors and nurses’ tasks are the repair of the machine and caring for it”.

According to the socio-medical paradigm, there is a clear link between the prevalence of health or ill health in any given population, and socio-economic and socio-cultural factors. During early capitalism in Europe with its rapid industrialization and urbanization, poverty and the adverse living and working conditions of the lower classes accounted for
their poor health and high rate of premature death. Insufficient nutrition, poor housing, inadequate hygiene, the extreme working day, lack of recreation and the noxious effects of work itself were identified as the most deleterious influences on health and well being.

The task of health services in change is to intervene in social and political life, to remove the unjust socio-economic and environmental conditions that hampered both the life of the consumers and or clients. Within general frameworks such as social hygiene and social therapy, the concept of social medicine was very broad indeed. There is overwhelming evidence today that the conditions and the prevalence of health and disease vary enormously between and within the regions of the world. The strikingly higher rates of morbidity and mortality in the less developed countries of the south, compared with the highly developed countries of the north, are generally explained by a serious shortage of food and by extensive poverty due to low socio-economic and political developments. The higher prevalence of poor health and chronic diseases among lower classes and minority groups in developed countries has to some extent been accounted for by their living and working conditions, which may produce excessive physical and psycho-social stress and foster lifestyles that are not healthy. It means that high-level of health/wellness or well being is an integrated mode of functioning that is oriented toward maximizing the individual’s potential within one’s environment. Thus a socio-ecological paradigm is a suitable framework for explaining the conditions and causes of health and ill health and for guiding health related activities as well as health and social policies. Hence, such a paradigm which integrates the bio-medical, the psycho-social and the socio-medical perspectives will serve as the main anchor for this inaugural lecture. The conceptualization of the interacting forces is as contained in figure I.
Figure 1. Factors that influence levels of health
Psychological reactions and illness experiences

In every culture, illness, the response to it, the experience and treatment of illness and the social institutions relating to illness are all systematically connected but not uniformly patterned. For most of us, the thought of being ill, disabled, dependent on others (be they professional carers or family members and partners), is an alien, stressful and a rather horrifying experience (Fajemilehin and Fabayo, 1991; Fajemilehin, Fabayo and Oladimeji 1993). Though contact with the health service is inevitable for many reasons (e.g. pre- and post-natal care, immunizations, following illness and health screening), the fear that can be generated and experienced, for example, because of the uncertainty of the process of diagnosis and prognosis, the impact of acute and traumatic experiences, negative connotations and the long-term effects of chronic illness, incapacity dependency and degeneration, are far reaching both for the individual affected and for those who intend (or are expected) to support them (Fajemilehin and Fabayo, 1991; Schober and Hinchliff, 1995; Fajemilehin and Oyelana, 2004).

It is not the intention to reiterate the debate about the nature of health and thus, what constitutes ill-health as this is fully explored in the lecture. However, it is important to emphasise how the intricate reactions which result from changes in health and experiences of illness may affect the individual particularly at a time when socio-economic inequalities in health appear to be increasing particularly in relation to young men and women from deprived areas, family and child poverty (Schober and Hinchliff, 1995; Fajemilehin and Ademola, 2001) as well as the elderly people. Hence, variables influencing the health behaviours of the individuals as presented in figure 1 are summarised mainly as follows that:

*Life style
*Perceived locus of control over events and situations
*Perceived ease or difficulty in accomplishing a task (self efficiency)
*Health care attitudes
*Self and family -concepts

which are products of cultural beliefs and values
This means that individuals determine their health status through their coordinated actions. Personal lifestyle in terms of a person’s actual daily activities and routines that are acceptable practices in the person’s life, be it consumption of large amount of caffeine, cigarette smoking, consistent intake of high fat foods, and or a sedentary routine, will surely affect the individual’s health status. Lifestyles are developed within one’s family and one’s cultural environment which serve as primary influence on a child’s development of health promoting or health defeating behaviours. The individual’s sense of control over events and situations along with others affect their lives. A person with an external locus of control feels like a victim but that with an internal focus of control feels able to influence significant events and occurrences affecting life and self. Thus, those with an internal locus of control are more willing to make lifestyle changes that will lead to wellness. Of importance also is self efficacy which measures the perception of one’s own ability to perform a certain task with a resultant powerful impact on initiation of change in behaviour (the strongest predictors of specific health behaviour). Beliefs are powerful shapers of behaviour, while attitudes about health and personal vulnerability are actually learned in the family as unit of health which afterwards, greatly influences behaviour and socialization. Self-concept, on the other hand, indicates the individual’s perception of self in terms of self esteem (self worth) and body image (physical self). Hence, these factors focus the following health promoting goals:

* respect and support patient’s/client’s ‘right to make and or take part in decisions on health;

* identify and use client/patient’s strength as assets; and

* empower client/patient to promote own health or healing (self care model).

The knowledge, and even the suspicion, that illness presence has the potential to cause a range of reactions. Many of these will be affected by and become dependent on such factors as age, finance and stage of maturation, the presence of mental illness, learning disability and behavioural problems. Hence, ‘Illness is often regarded as the person’s subjective experience of
ill-health’ (Fajemilehin and Fabayo, 1991; Schober and Hinchliff, 1995). The studies found a range of perceptions of illness which were categorized as:

* Normal - those that may be expected even though preventable, e.g. malaria, measles

* Real - those which result in disabling and life-threatening diseases

* Natural Health problems - include natural processes such as childbirth and ageing.

Illness tends to be regarded as a change in an individual’s physical state which is alien and undesired and disrupts usual social activities and evolvement of the total person. When caused by a recognized disease, the illness may be perceived as acceptable. Conversely, a range of diseases carry with them stereotypical responses which may influence the response to the individuals concerned, e.g. leprosy and mental illness still carry the stigma and labels which may alienate those suffering the symptoms of such from mainstream society (aai kole adete si igboro). Goffman (1990) identified three sources of stigma and labels that corroborated them all. These are, namely:

* ‘abominations of the body’, e.g. facial scarring, physical disability

* ‘blemishes of individual character’, e.g. homosexuality, emntal illness

* Tribal stigma of race, nation and religion’, e.g. colour, language and dress differences.

Illness as a source of stress for the individual is recognized as a significant life event (Holmes and Rahe, 1967; Fajemilehin and Fabayo, 1991). The response to illness is complex in as much as it may be a direct consequence of a stressor on the body, resulting in, for example physiological effects of stress such as increased blood glucose levels, increased corticosteroid activity, increases in blood pressure and heart rate, as well as general health-related responses, for example headaches, dizziness, diarrhea, insomnia and sweating. The emphasis on physiological response described by Selye (1957) and the corresponding defence
reactions which he refers to as the general adaptation syndrome (GAS), while contributing to an understanding of how stress and illness influence the body, do not provide necessary insight into how the psychological reactions to stress link with the physiological and thus affect the individual. Behavioural and cognitive responses to stress are well recognized (Cox, 1978) and include excessive eating, drinking, smoking, trembling, hesitancy, nervous laughter, restlessness, crying and lack of eye contact. Stress affects individuals in different ways and illness is no exception. The transactional model of stress described by Lazarus (1966) and Fajemilehin and Fabayo (1991) provided valuable insight into the importance of assessing how individuals perceive their situation. Individuals have the capacity of acting on and responding to the environment rather than being passive responders. Thus, it is advocated that individuals are encouraged to extrapolate their experiences, recognizing that their insights and awareness may be affected by coping mechanisms such as denial and disbelief (Schober and Hinchliff, 1995). Those faced with changes in health and disbelief, particularly those which necessitate care and support, react in a wide range of ways which may include the adoption of a number of the following, cognitive, emotional and behavioural strategies such as:

* shock
* disbelief
* confusion
* denial
* anger
* acceptance
* assuming a sick role
* learned helplessness.

Loss and coping

There are marked similarities here with reactions to loss, death and bereavement, in as much as shock, disbelief, denial, anger and grief,
and ultimately, acceptance, are clearly recognized as psychological and emotional responses (Saunders, 1990; Fajemilehin, Fabayo and Oladimeji 1993). There is a need to come to terms with the inner turmoil which is central to the experience of losing, control over one’s destiny. The grieving processes, sense of insecurity and potential isolation come from the threat of mortality and highlight, by way of introduction, and the links with the need for spiritual well-being.

Learned helplessness

Originally, the theory of learned helplessness was suggested as a model for understanding depression (Seligman, 1992). Seligman suggested, from animal experiments, that without a warning or predictor of danger or pain, the resulting continual stress may result in the development of ulcers. He went on to observe that among soldiers tortured in Vietnam, those who were able to maintain a degree of hope survived while others became ill and often died. The factor which appears to be crucial in this example of extreme and life-threatening onslaught is the element of control which individuals perceived they had over their situation. Feeling and being in control at times when there is a need or desire to adapt and cope depends on a wide range of factors including the understanding of the situation, a factor which will be seen later to be central to patients’ satisfaction with their care.

Attitudes and Values

Reactions to illness and disease may also be influenced by attitudes and values associated with our understanding of the mind, body and spirit (Fajemilehin, 1988). Kidel (1986) suggests that the body is seen as ‘inferior to the mind and spirit’ and may thus influence how messages about the functioning of the body are interpreted. Our sense of self-consciousness inhibits our body and, as Kidel (1986) further discussed that denial is a form of defensiveness, making coping with illness and disease harder to bear. The dualism associated with the traditional medical model in which the functions of the body are seen as separate from the mind and psychological responses has been a far-reaching influence on how both the providers of health-care services, particularly nurses and doctors, and recipients have perceived their roles. The price has been the suppression
of the emotional impact of the illness experience while prioritizing the physical, treatment-related components. The challenge is for us to take responsibility for our bodies, to listen to them and to take steps to understand the emotional impact of the illness experience and thus, to draw on our individual reserves as a means of coping. On our reactions to disease and illness, Kidel (1986) and Fajemilehin, Fabayo and Oladimeji (1993) suggested that: insecurity lies at the heart of our reaction to disease: when illness strikes, we feel as if under attack. The defences which have enabled us to ignore our potential for frailty and vulnerability are suddenly removed. We are no longer able to fulfill the social roles which provide us with a sense of identity. Business cannot be ‘as usual’ and instead of being busy, we are slowed down or immobilized and forced to break routines, go to bed, seek help and take stock. We no longer ‘feel ourselves’, as we are confronted with the full force of the unknown and the unpredictable and at the heart of our feelings about illness lies a universal fear of death, and associated anxieties about aging, decay and change. Kidel (1986) also asserted that it seems essential that we should come to terms with the unpredictability of our diseases and syndromes. We can never be certain of improvement, recovery, recurrence or deterioration. Our reconciliation with illness requires before all else a surrender to uncertainty and an acceptance of mortality. Hence, sickness is a complex social process that is consequential and only partly understood. Not only is a sick person likely to behave differently from one defined as “well”, the difference in the behaviour is perceived, expected and constitutes a distinctive social role defined in cluster of interrelated expectation. Parson (1951) proposed the concept of sickness that focused on sociological perspectives rather than medical.

The sick role

The analysis of the Parsons’ postulation of the concept of sickness provided the basis for the sick role defined with the following essential characteristics:

* Exemption of the individual from the usual social responsibilities
* Recognizing that the individual is not to blame for her or his illness.
The individual perceives that the sick role is undesirable and intends to get well (self care promoting factor).

The individual is obliged to get well.

The assumptions proposed by Parsons appear to have had far-reaching influence. While it can be acknowledged that not all patients fit this mould, the expectations which have been assigned patients usually by clinical staff, have had powerful consequences. The notion of ‘good’ patients refers to those, who, for example, conform, comply with instructions, appear passive (Leigh and Reiser, 1980) and concluded with ‘popular’ personalities and conditions (Stockwell, 1972). This may have played a significant part in the approach to patients, which have implied lower status, and resulted in poor information-giving and lack of involvement in decision making.

Figure 2: A recovering sick elder at home
Intrinsic interest and life

The intrinsic interest in preserving one’s own life is not simply an interest in sheer existence (though people will go to astonishing lengths merely to remain alive), but also an interest in good health. The suffering that accompanies poor health creates a constant imperative desire to improve it. An interest in the health of others, however, must be culturally engendered. Yet even this task would seem easier than the creation of an interest in procreation. To witness the suffering of intimate friends and relatives is hard, and to see them die is harder. With them a person has already established bonds of affection, whereas in contemplating procreation one is thinking of beings who are not yet real. Unless an individual is powerfully conditioned by cultural indoctrination, a failure to procreate is not so saddening as a failure to maintain his own health and that of his inmates. There are socio-cultural forces tending to maintain life or improve health, and others tending to do the opposite. These factors are for the most part traditional and non-rational, though the goal is so universal and immediate and consequently so little supported by social myth and dogma, that scientific means are fairly readily adopted when these become available. The greatest social mythology is required not for the preservation of life but for its sacrifice; whereas the greatest mythology is required not for the sacrifice of fertility but for its maintenance.

Some social impediments to health and longevity also existed in terms of the abandonment of the aged (Fajemilehin, 2000) and infirm, the exposure of deformed children, the execution of twins, the killing of female infants, the elimination of the painfully diseased, and the sacrifice of individuals for ceremonial purposes in agreement to the reigning law of the jungle which provided for the survival of the fittest due to assessed lack of great value to offer in their wisdom or experience. The understanding of these practices lies in a review of the folk theory which underlines them. Folk theory regarded disease and death as caused by spiritual, religious, magical and moral forces.
The Demographic Revolution

Worldwide, the proportion of people age 60 and over is growing faster than any other age sub groups. Between 1970 and 2025, a growth in older persons of some 694 million or 223 percent is expected. In 2025, there will be a total of about 1.2 billion people over the age of 60. By 2050 there will be 2 billion with 80 percent of them living in developing countries. Decreasing fertility rates and increasing longevity will ensure the continued “graying” of the world’s population, despite setbacks in life expectancy in some African countries (despite the extreme poverty, poor condition of living and scourge of AIDS) and in some newly independent states (due to increased deaths caused by cardiovascular disease and violence). Sharp decreases in fertility rates are being observed throughout the world. It is estimated that by 2025, 120 countries will have reached total fertility rates below replacement level (average fertility rate of 2.1 children per woman), a substantial increased compared to 1975, when just 22 countries had a total fertility rate below or equal to the replacement levels. The current figure is 70 countries. Until now, population ageing has been mostly associated with the more developed regions of the world. For example, currently nine of the ten countries with more than ten million
inhabitants and the largest proportion of older people are in Europe. Little change in the ranking is expected by 2025 when people aged 60 and over will make up about one-third of the population in countries like Japan, Germany and Italy, closely followed by other European countries (WHO, 2002).

Figure 4: Dilapidated houses where some of the elderly reside.
Population and society in Transition

Population of a given area at an earlier time is represented by \( P_1 \) and \( P_2 \) the population at a later time, then:

\[
P_2 = P_1 + (\text{Birth} - \text{Death}) + \text{Net Migration}.
\]

If \( r = (F - M) + (I - E) \) where \( r \) is rate of population growth, \( F \) is fertility, \( M \) is mortality, \( I \) is immigration and \( E \) is emigration put together, rate of population growth is determined by the natural increase plus the net migration, meaning that the secret of population lies in the relationship of the human species to its physical environment.

Persons who are of the age of sixty years and above nearly comprise 3.4 percent of 1963, 4 percent of 1980, and 5.2 percent of 1991 census figures, and it is expected to be greater than this in the subsequent years (FOS, 1963; NPB, 1988; NPC, 1994). Future predictions are that the elderly will continue to grow numerically at a more rapid rate than the population as a whole. Even, dramatic is the growth of elderly person who live alone between 1991 and 2000. The number has increased from 5.2 percent to about 6 percent of the population. In less than five years from now, the number of the elderly growing beyond sixty years of age may be very close to about 10 percent of the total population (Bamigboye, 1999; Fajemilehin, 2001).

Life expectancy is the average number of years that a person can be expected to live. It was Siegel (1982) who said that the increase of man’s lifespan by eighteen years in a period of fifty years was more revolutionary and had more profound medical, economic and socio-cultural implications for such things as atomic energy, air transport and modern communications (Population R. Bureau, 1999).

The main factors responsible for most of these increases in life expectancy have been the declining birthrate, reduction of infant and childhood mortality as well as control of infection through advances in medical technology in mid-span, coupled with decreased mortality among the middle-aged and elderly population (Bamigboye, 1999).

The elderly population is increasing more rapidly than the total population, and this, combined with the reduction in working hours, has produced considerable changes in society. And because more people are
living longer, health professionals will be expected to help the geriatric patient make these added years healthy and productive. The older adult referred to as “senior citizens” represents a social paradox in that, having laboured long and had to achieve an extended span of life, the society seems unwilling to provide much satisfaction for those at the end of the span of life; being unable to meet most of their needs. It is a supreme irony that this very society which values long life also tends to regard the aged as problems and liabilities. But if the older adults are a liability to the society, it must also be recognised that advanced age too is often a liability to the individuals. In terms of health when compared with younger age groups, the older adults have the higher prevalence of illness, visit the physicians more, spend more time in the hospital, endure more days of restricted activities due to illness, have less money with which to purchase health care and prone to chronic illness (Fajemilehin, 2004).

Man is an entity of social life experience that operates within the dynamics of change, since life is not static. The various processes of modernization, urbanization, industrialization, changes in polices (introduction of local government administration as well as political and economic instability coupled with the clamped down on traditional festivals) and the weakened state of the informal structure of the traditional extended family system have undermined the traditional position of the elderly today. All the structural changes associated with those processes have made the elderly powerless and isolated from the decision making processes in the society. The old established traditions of care, support and respect for the elderly are disregarded. The social networks amidst socio-economic change have abandoned the elderly because they are economically unable to support themselves (Peil, 1988). Discoveries in medical science and improved social conditions during the past few decades have increased the life span of man. People in the developed countries are living up to the age of 70 years and over.

Longevity

Longevity or growing old is a process and product of several factors such as genetic, active physical state, life styles, health behaviour and self management techniques that takes place in the human body.
even when the individual does not seem to be aware, which is concerned not only with the biological process of ageing but also with the socio-cultural and economic factors influencing it. Hence, old age cannot be linked with ill-health or disability, although it is a period of increased health problems to many due to changing economic ability, living arrangement and post modernization role changes (Ekong, 2006). Several studies (Fajemilehin, 2000; and Giddens, 2001) reported that females, with a few exceptions all over the world outlive their male counterparts- sometimes as much as 9-10 years longer on the average.

Influences on longevity

The longevity of Adam and some of his descendants who their ages range between 365 and 950 years (Genesis chapter 5) was explained to be as a result of the following perspectives:

* Human race being genetically purer
* Provision of water which were above the firmament and shielded people from environmental factors that hasten ageing (Genesis 1:7)
* God-given so that man would replenish the earth (Genesis 1:28) and later to 70-80 years because of man courting God’s wrath through his iniquities (Ps.90:7-9).

World-wide, there tends to have been a marked improvement in longevity and life expectancy. This according to Fajemilehin (2000) and Fajemilehin and Odebiyi (2009) could be linked to:

* Socio-cultural factors (truthfulness, contentment and experience of self-fulfillment in or successful culmination);
* Education and the general awareness of the leading causes of diseases;
* Improved nutrition;
* General improvement in socio-economic factors that affect health including the environment;
* The global positive change of attitudes toward women who reproduce and care for the society;
* Technological breakthroughs in drug research and manufacture (Immunocal);
* Breakthroughs in methods of diagnosis, disease prevention and cure of infectious and parasitic diseases;
* Expansion in recreation and leisure;
* Advances in communication, transportation and enhanced mobility;
* Institution of democratic governments and the rule of law as a universal ideology; and
* The growing perception and acceptance of development as being more than growth in GDP but embracing human development and holistic growth.

**Global factors in health development**

Countries no longer represent truly independent and sovereign states. Globalization is eroding national borders and facilitating the transfer of goods, services, people, values and lifestyles from one country to another. The policies of one country affect another country. This has turned the world into a complex entity of dependent and interdependent individuals, groups, and countries. National and local decisions on health and development are affected as never before by global forces and policies.

**Situation analysis**

Nigeria like other colonized countries experienced tremendous gains in health from the immediate post independence era. Life expectancy improved over the years; smallpox has been eradicated; the prevention of a range of communicable diseases such as measles, poliomyelitis, and diphtheria has improved child survival and development. These gains have
been due to advances in science, technology and medicine. Expanded health services based on the principle of Primary Health Care, as well as progress in education and socio-economic development, have also contributed to the gains.

However, in the last few decades, the pace of health development has stagnated. There has been little or no change in under-five and infant coupled with maternal morbidity and mortality rates. Experience of improved life expectancy was tale of regret for the elderly, be it retired or never employed due to lack of familial support and care, poor finances and government neglect. The resultant effects of which had worsened Nigeria’s human development index. A combination of factors such as gross financial mismanagement and lack of accountability coupled with low political will on the part of Government, changing lifestyles, nutrition, environment, and challenges in the health system, politically motivated policies may be the major factors contributing to stagnating health and development indicators.

Demographic and lifestyle changes

There have been a number of demographic and lifestyle changes over the years. The country’s population continues to be on the increase and becoming older, more urbanized and ever undergoing lifestyle changes; all of these have implications for health and development. The combined effect of the relatively high growth rate and the youthful and aging population will be to increase the pressure on social services such as health and education services. The demographic, lifestyle and environmental factors interact to present high levels of morbidity and mortality in the country. Nigeria’s disease profile is in summary characterized by high levels of communicable and pregnancy-related conditions, and by a rising number of non-communicable disease conditions.

Poverty and inequalities in health

Poverty is an identified cultural symbol of failure and a major cause of under-nutrition and ill health. It exacerbates the spread of diseases and reduces productivity. It undercuts the effectiveness of health services and slows population control. Indeed, health suffers most in situations where
economies have been unable to secure adequate income levels for all, where social systems have collapsed and where environmental, natural and human resources have been poorly managed. The poor, including the elderly experience a disproportionate share of ill health in the country. They often live in unsafe and over-crowded housing; they are more likely to be exposed to pollution and other health risks at work and in their communities. The sub group is also more likely to consume insufficient or rather unhealthy food and suffer from under-nutrition and micronutrient deficiencies.

Health Financing

The total fund available for health care has been increasing in the last few years from the improvements in the following sectors:

* Positive macroeconomic climate
* Increased allocation to the health sector from Government
* Increased donor in flows
* Introduction of the National Health Insurance Scheme

Finally, health financing is still a major hard nut to crack. The little increase in funding to the health sector has gone mainly into the payment of personal emoluments rather than to support service delivery. As a result, a major funding gap for scaling -up of priority public health needs interventions exist. At the same time the increase in personal emoluments has not risen to the point where the salaries in the sector can be compared with or match those of developed nations making regular brain drain of the sector’s human resources a heart felt concern.

Factors in longevity: Nigerians’ experience

In Nigeria today One hears and reads about death of many young ones today at 30, 40, or just close to 50 years of age and or a little over. In a society where illiteracy, poor nutrition, low status of women and regular exposure to environmental hazards co-exist with political instability, feud and harsh economic conditions of the nation, it is interesting to still find
elderly persons aged 100 years and above (Fajemilehin, Ayandiran and Badru; 2007). However, findings of Fajemilehin (2000) on what the elderly persons aged 100 years and over had put in place to achieve that level of active ageing/longevity and maintain health highlighted major issues on health behaviour patterns of the sub group. The highlight of the health promoting factors is summarized thus:

**Health promoting factors**

* Truthfulness
* Contentment
* Patience
* The use of the tongue (watch what one says) and observation of traditions
* Familial care and support
* Exercises in form of unrestricted daily activities
* Adequate and proper feeding in line with other traditional habits- i.e. low intake of cassava products, sugary sweet and refrigerated food items. (jeun to dara nitori ohun ti eye ba je ni eye maa gbe fo)
* Satisfaction with life past experiences (period of culmination)
* Compliance with home training e.g. respect for elders (in my days, young ones were made to respect the elderly person but today a boy of ten will willfully knock down a man of 50 without any mind of pity). It is believed that those disrespecting elders will incur the wrath/curse of the elders and such action will result in ill-health.
* Hardworking spirit (nitori ise sise kii pani aise re gaan ni abuku)
* Taking life easy with the fear of God(sise jeje pelu iberu Olorun)

The broad analysis of the highlight above on health promoting factors and growing old were well corroborated issues in 1ST Timothy 6 verse 6 and 11 which expressed that ‘there is great gain in Godliness, truthfulness with contentment’, while the verse 11 says “aim at righteousness, godliness, fight the good fight of the faith, love and patience. The health point of view agreed with the various analytical positions, since both truthfulness and contentment not only prevent fear, anxiety, and stress of life but also
promote peace of mind, thus preventing cardio-vascular, diabetes and other stress induced disease conditions. Of importance is “exercise” in form of unrestricted daily activities which provides for active state of musculo-skeletal function and alert state of the individual. Traditional habits (such as, use of chewing stick, restriction on starchy, sugary, and sweet as well as refrigerated food items) prevent, teeth, eye, and other systemic health problems. Virginity was a major traditional requirement for marital union in the olden days. Observation of this tradition not only prevents sexually transmitted infections, but enhances lasting love in marriage. The need to maintain all stages of marriage was also stressed as this will ensure successful marriages as unhappy marriages can negatively impact on the health of those concerned. Finally, Fajemilehin (2000) posited that longevity is a product of several bio-socio-cultural factors.

The positive effects of ageing

To an individual, living to old age

* May be an indication of possessing genetically strong disposition to have withstood the ravages of time;

* May offer Opportunity to retire and free oneself from the constraints of work;

* May bring honour, respect or high esteem in societies where experience and wisdom are ascribed to age;

* May bring personal satisfaction where the life had been a fulfilled one. In other words, the opportunity to eat the fruits of one’s labour and see the progress of the next generation is a function of how long one lives;

* May be the time to travel, learn new skills or pursue further education which one could not while in active service and/or carrying full parenting responsibilities. The negative effects of ageing

* Mandatory retirement from formal productive work. This may not apply to self-employed.

* Loss of friends, spouse and generational cohorts who may have died off. One may become an oddity in the society.
* Loneliness arising from the above and the struggle to bridge the generation gap.
* Loss of status and income.
* Dependence on others to do basic personal chores like bathing or personal hygiene and getting out of bed.
* Vulnerability to criminal attack because of perceived frailty.
* Need for change in living arrangement.

**Effects of ageing on the society**

* Loss of erstwhile physically strong and economically active or productive and experienced (Academic and Judiciary have a terrible bite of the situation) section of the population to retirement. Unless this is effectively countered by generational replacement or a liberal migration legislation, a skewed dependency ratio is likely to arise. This means the number of children below economically productive years, plus the number of persons 65 years and above as a proportion of those of working age.

* Increase in old age dependency ratio means more persons on pension and welfare than in production. Increase in life expectancy also implies more people being on pension for longer periods.

* Pressure on the public health care system

* Increase dependency on the children’s resources (including time) where the elderly live with their children as in Nigeria, leading to lower standards of living in the society.

**Some reactions to the aged or generational conflicts**

Where high value is placed on the youth, vitality and physical attractiveness, being old can become a problem to those affected. The consolation however is that those who are young today are bound to grow old tomorrow. In Nigeria, the youths are clamouring for the older generation to give way or at least integrate them into the power structure.
However, in the UK and other European Union countries the elderly have asked for the extension of the retirement age from 60 to 65 or 65 to 70 to compensate for increased life expectancy. Moreover, there is also the tendency to categorize persons by age rather than by characteristics, pursuits and identities. Some people have used such categorization to discriminate against and stereotype the elderly – a development aptly described in ageism. This new ideology is likened to racism or sexism (Young and Schuller, 1991). Activist groups have risen to fight this growing discrimination against and marginalization of the elderly in society insisting that the young and the old must co-exist and cooperate to create and ageless society.

Why do people age?

There is no any direct explanation to this except that ageing itself is seen as a complex process with great individual variation. However, literature proffered some theoretical explanation and bases of existence through biological and senescence theories. Biological ageing theories were arrived at after examining the basic ageing processes that affect all living organisms and try to explain their age related changes. Hence, these are summarized as follow:

Ageing is total scenario with the passage of time, a decline in the functions of the various organs in the body occurs, eventually leading to death. The cause of it is unknown but speculations include, the following:

* Biological clock in the hypothalamus presumable Growth Hormone which controls body functions and also initiates ageing and identical similarities.

* The release of free radicals (the reactive intermediate compounds of Oxygen) which include: super-oxide, peroxide and other residues. (Reactive Oxygen Species “ROS”)

Apart from ageing, various conditions that can trigger the release ROS or oxidative stress are inflammatory and immune responses, malignancy, diabetes and arteriosclerosis. The action of the free radicals
are enhanced by ischaemia and reduced by anti-oxidants such as beta-carotene, Vitamin E and Vitamin C.

* Genetic theory — explains the role of genes in ageing focused predetermined life span;

* Immunity theory — explains that component of immunity system are affected by ageing (immuno-senescence). This means that at older age, people are more susceptible to chronic illnesses such as cancer, arthritis, and cardio-vascular conditions;

* Free radical theory — free radical are very unstable and maintain molecules formed during metabolism in response to environmental pollutants and damage to cellular components (lipid and protein), antioxidants are among the major protective mechanisms however, these may become less effective with; and

* Apoptosis theory — is concerned with the normal process/mechanisms of cell death throughout life regulated by opposing genes. With ageing, the process becomes imbalanced and ineffective as age increases resulting in the visible disability and degenerative changes.

In Table 1 below, changes in the body system and functional status of the elderly persons are indicated, viz, age related changes, nursing assessment (subjective and objective findings), and health promotion strategies.
Table 1: Changes in the Body System and Functional Status of the Elderly Persons

<table>
<thead>
<tr>
<th>Age Related Changes</th>
<th>Nursing Assessment (Subjective and Objective Findings)</th>
<th>Health Promotion Strategies</th>
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<tr>
<td><strong>Cardiovascular System</strong></td>
<td>.Decreased cardiac output; diminished ability to respond to stress: heart-rate and stroke volume do not increase with maximum demand. .Slower heart recovery rate. Increase blood pressure.</td>
<td>Exercise regularly; pace activity; avoid smoking, eat a low fat; low salt diet; participate in stress reduction activities; check blood pressure regularly; medication compliance, weight control.</td>
</tr>
<tr>
<td><strong>Respiratory System</strong></td>
<td>.Complaints of fatigue with increased activity .Increased heart-rate recovery time. Normal .BP&lt;140/90mm Hg</td>
<td>Fatigue and breathlessness with sustained activity; impaired healing of tissues due to decrease oxygenation; difficulty in coughing up secretions.</td>
</tr>
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<td><strong>Integumentary System</strong></td>
<td>.Skin appears thin and wrinkled; complaints of injuries; bruises; And sunburn; complaints of intolerance to heat; bone fracture is prominent; dry skin.</td>
<td>Exercise regularly, avoid smoking; take adequate fluid to liquefy secretions; receive yearly influenza immunization; avoid exposure to upper respiratory tract infections.</td>
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<td>.Exercise regularly; pace activity; avoid smoking, eat a low fat; low salt diet; participate in stress reduction activities; check blood pressure regularly; medication compliance, weight control.</td>
<td>Avoid solar exposure (clothing, sunscreen, stay in doors); Dress appropriately for temperature; maintain a safe indoor temperature; shower preferable to tub bath; lubricate skin.</td>
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<th>Reproductive System</th>
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<th>May require vaginal estrogen replacement; GYN/urology follow-up; use a lubricant before intercourse.</th>
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<td>Female: Vaginal narrowing and decreased elasticity; decreased vaginal secretions</td>
<td>Male: Decreased size of penis and testes. Male &amp; Female: Slower sexual response.</td>
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<tr>
<td>Musculoskeletal System</td>
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<td>Exercise regularly; eat high-calcium diet; limit phosphorus intake; take hormones; and calcium supplement as prescribed.</td>
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<tr>
<td>Loss of bone density and osteoporosis; loss of muscle strength and size; degenerated joint cartilage</td>
<td>Height loss; prone to fractures; kyphosis; complaints of back pain; loss of strength, flexibility and endurance; joint pain.</td>
<td></td>
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<tr>
<td>Genitourinary System</td>
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<td>Seek referral to urological specialist; have ready access to toilet; wear easily manipulated clothing; drink adequate fluids; avoid bladder irritants (e.g. Caffeinated beverages; alcohol, artificial sweeteners); pelvic floor muscle exercises, preferable to learn via biofeedback. Consider urologic workup.</td>
</tr>
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<td>Male: Benign prostatic hyperplasia.</td>
<td>Urinary retention; irritative voiding symptoms including frequency, feeling of incomplete bladder emptying, multiple night-time voiding.</td>
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<td>Female: Relaxed perineal muscles, (urge incontinence) urethral dysfunction (Stress urinary incontinence)</td>
<td>Urgency/frequency syndrome, decreased “warning tune”, bathroom mapping. Drops of urine loss with cough, laugh, position change</td>
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<td>Gastrointestinal System</td>
<td>Complains of dry mouth, complaint of fullness, heart burn, and indigestion, constipation, flatulence, and abdominal discomfort.</td>
<td>Use ice chips, mouthwash; brush, floss, and massage gums daily; receive regular dental care; eat small, frequent meals; sit up and avoid heavy activity after eating; limit antacids; eat a high fiber, low fat diet; limit laxatives; toilet regularly; drink adequate fluid.</td>
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<td>Nervous System</td>
<td>Slower to respond and react; learning takes longer; becomes confused with hospital admission; faintness; frequent falls.</td>
<td>Pace teaching; with confusion with hospitalization, encourage visitors; enhance sensory stimulation; with sudden confusion, look for cause; encourage slow rising from a resting position.</td>
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<td>Special senses</td>
<td>Holds objects far away from face; complaints of glare; poor night vision; and confuses colours.</td>
<td>Wear eye glasses, use sun-glasses outdoors; avoid abrupt changes from dark to light; use adequate indoor lighting with area lights and night lights; use large printed books; use magnifier for reading; avoid night driving; use constricting colours for colour coding; avoid glare of shining surfaces and direct sunlight.</td>
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<td>Hearing: Decreased ability to hear high frequency sound.</td>
<td>Gives inappropriate responses; asks people to repeat words; strains forward to hear.</td>
<td>Recommend a hearing examination; reduce background noise; face person; enunciate clearly; speak with a low pitched voice; use non-verbal cues.</td>
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<td>Tastes and Smells: Decreased ability to taste and smell.</td>
<td>Uses excessive sugar and salts.</td>
<td>Encourage use of lemon, mint, spices and useful herbs.</td>
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**Absorption**

- Reduced gastric acid; increased PH (less acid).
- Reduced GI motility; prolonged gastric emptying.

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**Distribution**

- Decreased albumin sites.

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**Absorption**

- Highly proteins binding drugs: oral anticoagulants (warfarin), Oral hypoglycemic agents (sulfonylureas); Barbiturates Calcium channel blockers, frusemide (Lasix) Non-steroidal anti-inflammatory drugs (NSAIDs) sulfonamides, quinidine, phenytoin (dilantin).
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**Synthesis of risk factors of decline in functional status: main risk factor domains, definitions and strength of evidence based on findings.**

To achieve some aspect of this lecture and lay the groundwork for devising, improving and implementing strategies to prevent or delay the onset of disability in the elderly, I conducted a systematic literature review of longitudinal studies published between 1985 and 2000 that

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reported statistical associations between individual base-line risk factors and subsequent functional status in community-living older persons. Functional status decline was defined following and replicating Stuck, Walthert, Nikolaus, Bula, Hohmann and Beck (1999) as disability or physical function limitation. MEDLINE, PSYCINFO, SOCA, EMBASE, bibliographies and expert consultation to select the articles, 89 of which met the selection criteria were used. Risk factors were categorized into 14 domains and coded by two independent abstractors. Based on the methodological quality of the statistical analyses between risk factors and functional outcomes (e.g. control for base-line functional status, control for confounding, attrition rate), the strength of evidence was derived for each risk factor. The association of functional decline with medical findings was also analyzed.

The highest strength of evidence for an increased risk in functional status decline was found for (alphabetical order) cognitive impairment, depression, disease burden (Comorbidity), increased and decreased body mass index, lower extremity functional limitation, low frequency of social contacts, low level of physical activity, no alcohol use compared to moderate use, poor self-perceived health, smoking and vision impairment. The review revealed that some risk factors (e.g. nutrition, physical environment) have been neglected in past research. This review will help investigators set priorities for future research of the Disablement Process, plan health and social services for elderly persons and develop more cost-effective programs for preventing disability among them (details as contained in table 2).
<table>
<thead>
<tr>
<th>Domain</th>
<th>No. of studies (data-bases)</th>
<th>Specific definition</th>
<th>No. of studies (data-bases)</th>
<th>Instrument for which a positive correlation was shown in at least one study</th>
<th>Strength of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect</td>
<td>21(14)</td>
<td>Anxiety</td>
<td>3(2)</td>
<td>State-Trait anxiety Inventory Depression subscale of the Hopkins Symptoms Positive affect score Non-dysphoric depression GDS (Chinese (version)</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depression</td>
<td>11(8)</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Alcohol</td>
<td>16(13)</td>
<td>Heavy alcohol consumption</td>
<td>3(3)</td>
<td>Quantity x frequency</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No alcohol consumption</td>
<td>3(3)</td>
<td>Quantity x frequency</td>
<td>+</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>22(12)</td>
<td>Comorbidity</td>
<td>21(11)</td>
<td>Number of prevalent chronic conditions Number of incident chronic conditions Chronic disease score</td>
<td>+++</td>
</tr>
<tr>
<td>Falls</td>
<td>8(4)</td>
<td>Falls</td>
<td>8(4)</td>
<td>Single- and two-item question Fall calendar</td>
<td>++</td>
</tr>
<tr>
<td>Functional Limitation</td>
<td>16(11)</td>
<td>Decline in (observed and self-reported)</td>
<td>4(4)</td>
<td>Change in Musculoskeletal impairment Change in physical performance score</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7(5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Domain</td>
<td>Observation</td>
<td>Description</td>
<td>Evaluation</td>
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<tr>
<td>Hearing</td>
<td>16(12)</td>
<td>Decline in hearing function</td>
<td>Single-item question</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Reduced measured hearing</td>
<td>Whisper test single-item question</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Poor self-reported hearing</td>
<td>Multi-item question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>6(5)</td>
<td>High medication use</td>
<td>Number of medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>30(15)</td>
<td>High body mass index</td>
<td>Weight/Height² (kg/m²)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Low body mass index</td>
<td>Weight/Height² (kg/m²)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Weight loss</td>
<td>Measured weight loss (% of original weight)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td>22(14)</td>
<td>Low physical activity</td>
<td>Estimated total daily energy expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-rated health</td>
<td>13(8)</td>
<td>Poor self-rated health</td>
<td>Leisure activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>17(12)</td>
<td>Smoking</td>
<td>Single-item question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>21(11)</td>
<td>Low level of social activity</td>
<td>Currently smoking</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Low frequency of social contact</td>
<td>Former smoking Quantity</td>
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Table entries include: Reduced observed lower extremity performance; Reduced observed upper extremity performance; Poor self-reported lower extremity function; Poor self-reported upper extremity function; Decline in hearing function; High medication use; High body mass index; Low body mass index; Weight loss; Low physical activity; Poor self-rated health; Smoking; Low level of social activity; Low frequency of social contact; Three chair stands summary performance score; Single items of qualitative performance; Single items of timed performance; Arm strength impairment; Lower body functional limitation; Upper body functional limitation; Poor self-reported lower extremity function; Poor self-reported upper extremity function; Low frequency of social contact.
4. Meta-analysis on the Synthesis for main risk factors

The domain ‘affect’ as an example was used to explain the data listed in Table 2 and to describe the synthesis process that was performed for each domain. The various studies reported results for the risk factor domain ‘affect’ which was defined as anxiety and depression. The remaining seven studies included various single-item mostly non-validated measures of emotional state. Since the majority of studies in this domain ‘affect’ were based on validated measures of anxiety and depression, these seven studies using single-item measures were not rated because they would not have added relevant additional information about this domain.

### Affect

The total analysis revealed a significant association between anxiety and functional status only in bivariate analyses. This association was supported by the systematic analysis of Penninx et al. (1998) that depressive symptoms were significantly associated with subsequent decline in physical performance.

### Alcohol

Overall, 16 studies analyzed the impact of alcohol consumption on functional status decline. A main limitation of all studies was the lack of a detailed evaluation of alcohol consumption based on information about quantity and frequency of drinking alcoholic beverages. There was evidence that heavy alcohol consumption compared to moderate alcohol consumption is associated with an increased risk of functional status decline. However, due to the low prevalence of heavy drinking in women, this
association was significant only in men (LaCroix et al., 1993). On the other hand, older men and women who consumed small to moderate amounts of alcohol were more likely to maintain mobility than non-drinkers. This observation might be related to the fact that moderate alcohol consumption has been associated with a decreased risk of cardiovascular events.

**Cognition**

The association of cognitive impairment with functional status decline was strong. Most studies used validated dementia screening tests as predictor variables. Gill et al. (1997) demonstrated that among the various components of the mini mental status examination, orientation and memory items had the strongest predictive value.

**Comorbidity**

All studies used count measures for quantifying comorbidity. Guralnik et al. (1993) showed that the presence of a single chronic condition was already a significant predictor of functional status decline, with the risk increasing incrementally up to the presence of four or more chronic conditions. One should take into account that simple count measures are a crude measure of comorbidity given the high variability in the strength of association between individual conditions (e.g. stroke versus degenerative joint disease) and functional status.

**Falls**

Based on a sample of over 3000 persons, Wolinsky et al. (1992) and Dunn et al. (1992) showed that only a history of multiple falls, and not one of a single fall, predicted poor functional outcomes. Tinetti et al. (1995b) demonstrated that the predictive value of a history of falls disappeared if baseline physical performance, affect and sensory impairment were included in a multivariate predictive model, indicating that a history of falls might rather be an indicator of the presence of other risk factors and not an independent risk factor per se.
Functional limitation

According to the model by Verbrugge and Jette (1994), functional limitation is a precursor of disability. Therefore, for rating the strength of evidence of functional limitation as a risk factor in the various studies, the meta-analysis revealed the association of functional limitation (i.e. upper or lower extremity limitation) with subsequent disability (i.e. difficulty doing activities of daily life including self-care, household and advanced physical activities). Both observed and self-reported functional limitation were evaluated as early predictors of subsequent disability. Guralnik et al. (1995) demonstrated that among non-disabled older persons living in the community, objective measures of lower-extremity function were highly predictive of subsequent disability. According to an analysis by Tinetti et al. (1995b), both upper and lower extremity function each has an independent impact on functional outcomes. Lawrence and Jette (1996) found that lower extremity functional limitations were stronger determinants of subsequent disability as compared to upper extremity functional limitations. There was only a weak association of self-reported measures of upper and lower extremity function with subsequent disability.

Hearing

The association between hearing impairment and functional status decline was weak. For example, Rudberg et al. (1993) showed that the predictive value of hearing impairment disappeared if the model controlled for age and comorbid conditions. Furner et al. (1995) demonstrated an impact of hearing problems on subsequent decline in instrumental activities of daily living, but this association was explained by the strong correlation with the telephone use sub item. An alternate explanation for the poor association between hearing and functional status is the fact that most studies used crude measures of hearing impairment, such as single item questions, or they combined deafness and trouble hearing without taking into account the functional consequences of hearing impairment.

Medications

Tinetti et al. (1995b) found that persons on five or more medications had worse functional outcomes than those on fewer
medications. Magaziner et al. (1989) demonstrated that the correlation between medication use and functional status decline remained significant even when controlling for comorbidity and baseline physical function. This observation suggests that the information about medication use does not contain information about comorbidity alone, but includes other aspects such as the severity of the comorbidity or the probability of iatrogenesis or inappropriate medication use.

**Nutrition**

Most studies measured nutritional status based on Body Mass Index. Five studies analyzed the effect of low, normal and high body mass index on functional status outcome. For both high and low body mass index, there was evidence for an association with functional status decline. Although the effect of overweight decreased after adjustment for chronic conditions, it remained statistically significant in a cohort of middle-aged and older women (Launer et al., 1994). Similarly, the increased risk of functional status decline associated with weight loss remained statistically significant even after adjusting for single or multiple conditions in multivariate models (Launer et al., 1994). Several studies analyzed the effect of other potential nutritional risk factors on functional status, such as various anthropometric measures (e.g. waist to hip ratio, skinfold) or dietary factors (Haga et al., 1991; Hubert et al., 1993; Seeman et al., 1994b). These factors were mostly tested in bivariate models alone and have not been proven to be superior to measures of body mass index or weight loss.

**Physical activity**

A lack of physical activity was independently associated with an increased risk for functional status decline. Three studies (Mor et al., 1989; LaCroix et al., 1993; Seeman et al., 1995) demonstrated that this correlation was present even for selected samples of active persons and even if the statistical models corrected for coexisting chronic conditions. Clark (1996) found that with increasing walking frequency there was a continuous tendency of better functional outcomes.
Self-rated health was measured with a validated question on subjective general health, mostly based on the categories excellent, very good, good, fair and poor (Goldman et al., 1995). Idler and Kasl (1995) and Goldman et al. (1995) concluded that self-rating of health controlling for baseline functional ability, health and socio-demographic status is independently associated with change in functional ability over periods of one through six years, with an approximately 2.5 times greater risk for declining in those with fair or poor self-ratings as compared to those with good and over self-ratings.

Smoking

There was strong evidence that current or former smoking is a risk factor for functional status decline. In studies differentiating between current and former smoking, current smoking was more strongly associated with functional status decline as compared to former smoking (Liu et al., 1995).

Social factors

There is good evidence that a low level of social activity and a low level of social contacts are associated with poor functional outcomes, even if correcting for potential confounding factors. For example, Moritz et al. (1995) found that social isolation and lack of participation in social activities were associated with incident limitations in activities of daily living suggesting that after accounting for cognitive functioning, maintaining an active lifestyle may help to postpone functional decline. Greater frequency of emotional support from social networks, particularly among those reporting low frequency of instrumental support has a favorable impact on functional outcomes (Fajemilehin, 2000).

Vision

Poor self-reported vision was associated with an increased risk of functional status decline. Most studies used single-item questions or clinically oriented multi-item questions. There was also evidence that reduced visual acuity (e.g. measured with the Rosenbaum chart) was
associated with functional status decline. Only one study analyzed the association of vision impairment based on visual acuity measurement with subsequent functional status decline in a model controlling for potential confounders (Salive et al., 1994). This study found that participants with severe visual impairment had three-fold higher odds of incident functional status decline as compared to those with visual acuity of 20/40 or better. Components of visual function other than visual acuity have not been addressed by the included longitudinal studies. One cross-sectional study suggested that contrast sensitivity, disability glare and stereoacuity might predict disability as well (Adegbehingbe, Fajemilehin, Ojofeitimi and Bisiriyu, 2006).

**Specific conditions and clinical findings**

Many studies reported the impact of self-reported conditions and clinical findings on functional status outcome. There were two limitations with regard to rating the conditions and clinical findings as predictors of functional status decline. First, the definitions of conditions and clinical findings were extremely variable and pooling of the findings about symptoms would have been misleading. Second, the statistical control for confounding was extremely variable between studies, further reducing the comparability of significant and non-significant results of conditions and clinical findings. Therefore, rating of these conditions would have been misleading. The conditions for which 10 or more of the studies reported significant associations with subsequent functional status decline included hypertension, stroke or transient ischemic attacks, diabetes and arthritis.

**Other factors predicting functional status decline**

**Socio-demographic factors**

Socio-demographic factors show strong associations with functional status in both longitudinal and cross-sectional studies. Chronological age is probably the most important factor, with an increase in the relative risk of functional status decline of about 2.0 for each 10-year increase in age (Guralnik et al., 1993 Fajemilehin, 2000). The risk of new onset disability is similar between men and women if other factors such as chronic conditions are controlled for in the multivariate models.
(Guralnik and Kaplan, 1989; Boult et al., 1994). Although the incidence of disability was found to be similar for males and females, females survived longer with incident disability than did males, explaining the higher disability prevalence among females (Katz et al., 1983; Strawbridge et al., 1992). Although race seemed to play a role for determining the prevalence of disability, this association was explained by lower socio-economic status in black as compared to white people (Mendes de Leon et al., 1995). Berkman et al. (1993) demonstrated that low functioning subjects were almost three times as likely to have an income of $\geq 5000 compared to the high functioning group. Higher educational level is associated with better functional status (Snowdon et al., 1989; Guralnik et al., 1993). The direction of the correlations of marital status and functional status depends on gender, social environment and socio-economic status (Goldman et al., 1995; Fajemilehin and Feyisetan, 2000).

**Psychological factors**

Several studies published findings about the association of psychological factors, such as locus of control or self-efficacy and functional status decline (Strawbridge et al., 1993; Seeman et al., 1995). Although there was some evidence that psychological factors predict functional status, the definition of these psychological factors were variable and rating of strength of evidence would have been misleading.

**Interactions between risk factors**

Only few of the included studies addressed interactions between individual risk factors. Laforge et al. (1992) reported that the combination of hearing and vision impairment had a higher impact on subsequent functional status compared to individual organ impairment. LaCroix et al. (1993) demonstrated that the association of alcohol use with functional status differed between subjects with and without baseline chronic conditions. The interactive effects of emotional and social support are another example of the sometimes complex interactions between risk factors of functional status decline (Seeman et al., 1995).

Some excluded cross-sectional studies revealed relevant findings about potential interactions as well. For example, Verbrugge et al. (1991)
found that severe overweight is a disability risk factor for people with arthritis, but not for those without arthritis (Fajemilehin, 2000). Kington and Smith (1997) described that a main determinant of the functional effects of three chronic conditions (hypertension, arthritis and diabetes) was the socio-economic status of the affected people (Fajemilehin and Feyisetan, 2001).

The general position of the meta-analysis from a policy perspective, revealed three main conclusions. First, the review has resulted in findings that have clear implications for future research. It is now apparent that several potential risk factor domains have not been adequately investigated in previous research. For example physical environment, nutritional status and social support have not been sufficiently addressed. Furthermore, this review demonstrates the urgent need of using better validated and more uniform measures of both predictors and outcomes, and it shows that most studies used traditional designs with single baseline and a one-time follow-up measure, often excluding subjects who died during the follow-up from the analyses. Newer methods, taking into account various trajectories of health and function, have shown promising results (Stuck, Walthert, Nikolaus, Bula, Hohmann and Beck, 1999; Fajemilehin, 2008) and should be employed in future work. Additional research is also necessary to further explore interactions between and among risk factors. For future work, the availability of a database with all longitudinal studies dealing with risk factors of functional status decline would be helpful. Currently, the lack of a system for identifying these studies and for having uniform information about methods and results of the studies is a major barrier for conducting a systematic literature search.

Secondly, clarification of risk factors for functional status decline might be useful for planning social and health services. People with functional status decline have special needs for long-term care services. Traditionally, age and gender distributions had been used for determining projected needs of services in a given geographical area. However, with the availability of more specific risk factor profiles, it would be possible to screen for risk factors of functional status decline on a population level and to more accurately plan for adequate future provision of medical and social services, including ambulatory and institutional care.
Finally, and most importantly, the results of this analysis have implications for the development of better methods for preventing the onset of disability in older persons. Only with a better understanding of the underlying risk factors and the related mechanisms of the Disablement Process is it possible to make more effective and more efficient programs to prevent or delay the onset of disability in older people.

Major social problems of the elderly persons

People concerned with social policy, providing services or planning programmes for the elderly, Social workers, Economists, Politicians and Gerontologists divided the key social issues of the subgroups into five broad categories. The 5 distinct groupings are:

+ Income—certainly, the basic and most central issue for the elderly in any society. It is obviously complex, critical, and intertwined with the larger problem of poverty, welfare and discrimination. This will be a resultant effect of economic obsoleteness secondary to decreased strength, activities of daily living and retirement.

* Health — the elderly person becomes more vulnerable due to ageing process and degenerative changes.

* Housing— limited with income, and state of bodily degenerative changes, the elderly need to be in kind of housing that meets their health and aesthetic needs as well as being located where they want to live and where they can readily get to visit places that are of interest to them.

* Transportation—— must be truly available to their residence, economical, safe, convenient, designed with the needs of the elderly. Hence, transportation is an essential need of the elderly to participate in spiritual, cultural, social and other recreational activities. Since it is a significant problem in rural areas, there is often none at all available and distance will then pose a major barrier to health care, social interaction, and community participation among the sub group.

* Nutrition — resulting from poor income, decreased gastro-intestinal secretions and other degenerative factor, the elderly may end up in a
poorly nourished state. Hence, the elderly needs education about nutritional needs, sources, preparation, feeding regiment and committed career.

* Special concerns of the elderly include—employment and retirement, spiritual needs, age discrimination, legal services, crime coupled with feud, and family today and social support for the elderly,

**Effects of drug—nutrient interactions in the elderly**

The elderly, because they are large takers of prescription and nonprescription drugs, may be at higher risk for adverse effects between drugs and food than the younger population. While we know that the elderly are more likely to need prescription drug for chronic disease control, we also know that drug used by many in this population group does not meet desired therapeutic goals. What is more, is the risk of adverse effects of such drugs on nutritional status of the subgroup?

The elderly individuals who take medications to control cardiac, arthritis, neurological conditions, and diabetes are at risk for identifiable and predictable adverse effects on nutritional status. Many elderly individuals with hypertension and congestive heart failure take diuretics and other hypertensive drugs which can adversely affect mineral balance. While, digoxine in either high or prolonged dosages can cause nausea, loss of appetite and severe weight loss, but they also take diuretics which cause potassium deficiency, muscle weakness, and ultimately cardiac arrhythmias which can be fatal. Those who suffer from osteoarthritis, gout, and rheumatoid arthritis are regular users of aspirin, ibuprofen and other anti-inflammatory drugs to relieve joint pain. Aspirin causes bleeding into the stomach giving rise to anaemia; and ibuprofen causes fluid retention leading to weight gain. Those with gout usually will take colchicine which impairs nutrient absorption and can cause weight loss. Rheumatoid arthritis are frequently debilitated and consume cortisone-like drugs or penicillamine to reduce joint swelling. These consumed drugs increase body weight, elevate blood sugar; and can also impair calcium absorption and osteoporosis. Penicillamine consumption can cause zinc deficiency leading to loss of appetite, impaired wound healing, and skin rashes; and it can also cause vitamin B₆ deficiency which is usually associated with anaemia.
Elderly individuals with neurological or mental health conditions cannot but take tranquillizers such as chlorpromazine and lithium carbonate which increase appetite leading to weight gain. Anticonvulsant drugs (phenytoin and Phenobarbital) can induce vitamin D deficiency, with loss of bone calcium; or folate deficiency leading to anaemia. Those who drink no milk are at the highest risk of vitamin D deficiency. These data clearly indicate an urgent need for increased awareness of the full range of factors which comprise diabetes management one of which may well be drug-nutrient interactions. Alcohol increases excretion of zinc leading to slow wound healing; of potassium leading to muscle weakness; and of magnesium leading to electro-cardio logical changes and delirium tremens. Alcohol also interferes with activation of vitamin $B_6$, and disturbs vitamin D metabolism leading to decreased calcium utilization and ultimately increased incidence of osteoporosis (Powers and Moore, 1986). Alcohol not only displaces food from diet, it also suppresses appetite.

**Effect of over-the-counter drugs on nutritional status**

Because many elderly individuals suffer from multiple health problems they are also inclined to self-medicate to gain relief from stomach upset, constipation, diarrhea, chronic coughs, body weight, and muscle aches and pains. Commonly used over-the-counter (OTC) drugs include laxatives, antacids, and diarrhoea medicines, cold and cough medicines, pain killers, tonics, and vitamins and minerals.

While many OTC drugs may be cheaper or easier to buy than to go to the doctor, several may impose a nutritional risk (Roe, 1987). Laxative use appears to be the most common non-prescription self-medication in the U.S. where approximately 50% of the over 60 population is reported to take occasional or regular dosés of laxatives. Laxatives use also increases with age. Mineral oil, phenolthalien-containing laxatives (Ex-lax, Feen-a-mint, Correctol, Alophen, Agaral, Evac-U-Gen, Trilax); bisacodyl (Dulcolax); senna (Senokot), and castor oil all reduce the absorption of vitamins A, D, E and K and may precipitate nutrient deficiencies.

Antacids (Tums) which contain calcium carbonate decreases the absorption of iron and certain prescription drugs. Sodium-containing antacids (Alka-Seltzer) can increase the risk of heart failure in cardiac
patients and can interfere with blood pressure control. Antacids (Maalox) which contain aluminium hydroxide can cause muscle weakness. Pain pills containing aspirin can cause anaemia due to bleeding into the stomach. Cough and cold medicines which contain ephedrine increase blood glucose levels in diabetes. High doses of vitamin A pills can cause headaches and bone pain.

Caring

Just as praying to God is a foundation of the spiritual life, so is caring for others. The fine Jewish theologian Martin Buber put it well when he said: "He who loves brings God and the world together". So many people are in such pain today. So many people are suffering and are in need of our understanding and support. But the questions remain: How can we do this in today’s stressful world? What would a caring attitude involve for a person who wishes to embrace a full spiritual life? To answer this, it is probably a good thing to know not only what caring is but also
what caring is not. Being available to others is not just giving time, money, and effort. It is not also endlessly worrying about others so that our personal tension rises to the point that we are overloaded and have no energy to care about anything or anyone else. After all, what would such imprudent masochism prove? Instead, being really available to others is being creatively alive for, and with, them. The true goal, which unfortunately often gets distorted or lost, is to share the Lord with others while others in turn are look for and enjoy his sometimes almost-hidden presence as it is revealed in them. And so, caring is “not in saying a lot of words to people, not in completing a compulsive list of works, and not in trying to respond to everyone’s expectations (including our own!), but in trying, with all of our being, to develop an attitude of openness and alertness in our interactions with others which is based on only one thing: the desire to look for and bring God everywhere.” And a cornerstone of such a wonderful form of caring is the beautiful gift of presence. Caring also involves a degree of necessary pain. As one rabbi said many years ago: “When you reach down to help others who have fallen into a ditch, you have to be prepared to get a little dirty yourself.” In addition to appreciating the value of “presence” and having an awareness of the realistic toll we must sometimes pay in reaching out to others in need, a caring attitude also, at its very core, involves embracing a special kind of willingness. Willingness in this perspective is in terms of listening, openness, and faithfulness. Listening, in and of itself expresses being really caring, truthful, willing, providing reflection, feedback, and questions to see if we both define the issues clearly, coupled with willingness to work with the client on gaining new perspectives on the problems and question at hand, as a universal value that directs practice (Fajemilehin, 2000; 2004). Caring then is an intentional intervening interaction initiated out of the care-giver’s and receiver’s perceptions that something/someone is unwell, unsafe, at risk, or in need; the interaction is embodied in shared/mutual attitudes and feeling of concern for each other. It refers to the level of emotional involvement between the care givers, be it formal or informal and the client through seeking the client out, spending quality time with, providing emotional support, paying attention to needs or ensuring manipulative therapeutic actions (Fajemilehin, 2000; 2004). Hence, it is not only the bedrock of, but the soul of nursing, what clients want, and need most from nurses. Meaning that, it is being
there, willing, and able to nurture others are hallmark of the effective and proficient nurse. Roberts (1990) discusses the hidden aspect of caring by saying, “The hidden ness of caring reflects the care giver’s intent to preserve a person’s integrity during dignity-stripping, painful, and sometimes embarrassing situations”. It is during these situations that clients are least able to perform self care and thus most need Care. Thus, caring is more than an intuitive process which can be learned both intellectually and interpersonally. It is a process and an art that require commitment and knowledge. Caring is a combination of behaviours and attitudes demonstrated when nursing actions are implemented that expresses it be it at the informal or formal level as contained in figure 5. The totality of which determines the state of well being, outcome of illness and survival of illness trajectory.

Figure 5: Reinforcement of Preconceived Ideas in caring process.
Caring and Expressions of family Stability

Health is the product of anxiety and well-being interacting and vacillating as caring situations change, become stable, and change again (Freidman, 1995). Lazarus’ (1966) achievement with stress processes in the mid-1960s, and the published research on caring and caregivers over the past two decades, provide a base for this lecture.

In this framework of systemic Organization, a healthy system is viewed as being free from deliberating anxiety and successful in balancing the four systemic targets of stability, growth, control, and spirituality so that congruence, or harmony, is established within and with the environment. In attempting to achieve a dynamic state of equilibrium (i.e. congruence), family behaviours may take on diverse patterns (Freidman, 1995). For example, some caregivers of stroke survivors deny the resultant changes in the family system; they deal with the caring situation by disengaging from the person with stroke. Others choose more adaptive ways by using such problem-solving techniques as holding family meetings to discuss the problems. Freidman noted that such reactions are based on the family’s overall style or basic pattern of functioning (1995). The family’s style is defined by its emphasis on the four process dimensions (i.e. system maintenance, system change, coherence, and individuation) and the behaviour patterns within them (Fajemilehin and Ade-Ademola, 2000). According to Freidman (1995) and Brauer, Schmidt and Pearson (2001) well-being and satisfaction with the situation and the family are indicators of health (1995). Definitions for health, the systemic targets, process dimensions, and congruence are listed in Table 3.
<table>
<thead>
<tr>
<th>Item</th>
<th>Sub-Item</th>
<th>Description/Implication</th>
</tr>
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<tbody>
<tr>
<td>Health</td>
<td></td>
<td>Freidman (1995) described health as the freedom from debilitating anxiety derived from successfully balancing four systemic targets so that a satisfactory level of congruence with and within the environment is gained. Family health is the outcome of an interpersonal process in which the four targets of stability, growth, control, and spirituality are dynamically balanced in accordance with the changing situation of the family.</td>
</tr>
<tr>
<td>Systemic Targets</td>
<td>Stability</td>
<td>Stability in the family refers to the maintenance of identity in tradition, values, and cultural beliefs.</td>
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<td></td>
<td>Growth</td>
<td>Growth refers to the ability to change through new understanding and examination of beliefs.</td>
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<td></td>
<td>Control</td>
<td>Control focuses on the organizational and regulatory functions of the family with the aim of minimizing or regulating the effect of change.</td>
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<tr>
<td></td>
<td>Spirituality</td>
<td>Spirituality targets connectedness and belonging and results in acceptance of change through adjustment of the system's own patterns and rhythms to those of other systems. Spirituality is based on values concerning commitment, love, and affection.</td>
</tr>
<tr>
<td><strong>Process Dimensions</strong></td>
<td>Process dimensions are actions of behaviours rooted in values and beliefs used to pursue the systemic targets. To maintain congruence within the family, caring behaviours for the care recipient relate to family style and pertain to four process dimensions: system maintenance, system change, coherence, and individuation.</td>
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<tr>
<td><strong>Systemic maintenance</strong></td>
<td>Systemic maintenance consists of behaviours that are grounded in tradition, refer to the structure and process of the family, and pertain to organizing and operating the family business. System maintenance comprises roles, rules, organizational patterns, rituals, decision making, power structure, and division of labour; it targets control and stability.</td>
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<tr>
<td><strong>System change</strong></td>
<td>System change refers to major alterations of system operations that result in shifts within the traditional family value system, requiring the operation and agreement of all family members. System change targets growth and control in that new information is incorporated and channeled; values and adjustment of beliefs are tested; behaviour patterns are adjusted to concur with new values; and new patterns are incorporated into system maintenance by changing and eliminating old ones.</td>
<td></td>
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</table>
| **Coherence** | Coherence refers to emotional bonding and caring relationships among family members; it targets the spirituality and stability. For example, the family may
share concerns, participate in joint activities, and provide mutual support for one another.

<table>
<thead>
<tr>
<th>Individuation</th>
<th>Individuation refers to the family’s promotion of individual learning and changing attitudes, assimilating and incorporating information, and sharing opinions and beliefs. Individuation targets spirituality and growth, because through communication the family encourages examination of the new values suggested by its members and initiates system change.</th>
</tr>
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<tbody>
<tr>
<td>Congruence</td>
<td>Congruence occurs through balancing and reconciling the four targets in many areas of daily living. Although congruence is continually sought, it is never fully realized because changes and conflict continuously threaten the system’s operation.</td>
</tr>
</tbody>
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Systems strive toward *congruence*, which is defined as harmony, computability of patterns and rhythms of subsystems, systems of contact in the environment, and the universal order (Freidman, 1995). Incongruence or disharmony and incompatibility among systems cause tension and prevent the free flow of energy. Well-being is the affective indicator of congruence, whereas tension is evidenced as anxiety or incongruence. Stability, a component of well-being, addresses traditions and common behaviour patterns rooted in basic values and cultural beliefs (Fajemilehin, 2000; Fajemilehin, Adetayo and Monehin, 1998; Fajemilehin and Ade-Ademola, 1999). Stability is embedded in sets of values, attitudes, and rules of life (Freidman, 1995). Each family adopts explicit and implied rules that members are required to follow. Caregivers follow these rules to prevent disturbing the caring situation. A caregiver’s personal system reflects
subjectively the level of well-being based on what is learned from the caring situation and in interaction with the family system and the environment.

This researcher was for 2 years the co-facilitator of a support group in Jamaica for persons caring for family members who had survived a stroke. In this group setting, the caregivers discussed their experiences and provided one another with individual support. They discovered that feelings of anger, guilt, grief, loss of control, helplessness, anxiety, vulnerability, and fear of the future were also experienced by others in the group (Fajemilehin and Balogun, 2009; in press). Most family caregivers reported some role change in describing their interpersonal caring experiences. Caregivers were encouraged by other group members to deal with the reality of their situations, including role conflicts and changes. An atmosphere of hope existed in the group, as the caregivers discovered that their experiences and problems were not unique (Pierce and Salter, 1988).

Although, the caregivers’ experiences may be similar to those of persons caring for others with chronic illnesses, caring for stroke survivors may result in uniquely difficult situations for the family. Little is known about how a family contributes to the problems associated with the caring situation. It is critical that rehabilitation nurses understand the caregiving experience and what it means to caregivers of persons with stroke and to their family system.

Understanding this is particularly significant because approximately 4 million people in this country live with the effects of stroke (American Heart Association, 2001). Stroke can result in cognitive, emotional, social, behavioural, and functional impairments (Dorsey and Vaca, 1998; Galarneau, 1993), creating considerable problems for families that are caring for the affected person. For low-income, urban family caregivers, these problems with caregiving may be magnified because of meager or depleted resources and the social problems that are compounded by the erosion and decay of many urban communities (Wacquant and Wilson, 1989). Caregivers of stroke survivors, as members of family subsystems, may deal daily with caregiving problems that overweigh any stressor the average suburban family know (Freidman and Musgrove, 1994).
Annually in the developed countries, 500,000 persons have an initial stroke, after which they have an average life duration that exceeds 5 to 10 years (Bronstein, Popovich and Stewart-Amidei, 1991) and costs $30 billion a year (Stephenson, 1998). These statistics are from previous research conducted primarily with all-white persons. Broderick et al. (1998) placed the incidence of initial stroke at 700,000 per year in a study that included 14% African American participants. That number is approximately 200,000 more strokes annually than have been reported in the literature, with the survivors having similar life expectancies of 5 to 10 years. African Americans present a unique public health problem because they experience epidemic rates of stroke; as are other minorities and women, they are underrepresented in research studies. Nursing can address these problems by conducting research focused on caregivers of stroke survivors within an African American family system in community settings. Therefore, the study examined how the component of stability affects caregivers' well-being and the functioning of their African American families. A secondary aim of the project was to examine the proportions underlying the Framework of Systemic Organization by Freidman (1995).

Incongruence: In the care of stroke survivors, the individual roles within the family may become unstable. It has long been known that if socially prescribed roles are in conflict with an individual’s acquired concept of self, the possibility exists for psychological anxiety or stress (Lazarus, 1966). Lazarus’ work was a marked change in stress conception; it was process-oriented and integrated a range of views expressed earlier by others. Lazarus cited Haggard’s (1949) work as representative of what the stress process would become over time: “An individual experiences stress when his overall adjustment is threatened, when his adaptive mechanisms are severely taxed and tend to collapse” (p. 458). Such stress and instability may occur in caregivers’ relationship, as the caregivers take on roles that were previously fulfilled by stroke survivors.

Lazarus’ position has been supported by several studies. A descriptive study by Williams (1993) examined the health and well-being of caregivers for persons with stroke; a project by Segal and Schall (1996) described differences in caregiver stress related to the functional ability of
the persons with stroke; an exploratory study by Grant and Davis (1997) explored caregivers’ personal losses from caring for persons with stroke; and Draper, Poulos, Cole, Poulos, and Ehrlich (1992) studied elderly co-resident caregivers of persons with stroke and dementia. Although Williams’ predominantly female sample of caregivers had relatively few physical symptoms, considerable emotional distress was reported in terms of anxiety, depression, and anger. Segal and Schall noted that the greater the functional impairment of the person with stroke and the resultant role changes for all involved, the higher the caregiver’s level of stress within the first few months after the stroke. Grant and Davis reported strain and loss of self as the caregiver assumed new roles. Abel and Nelson (1990) found that depression and anxiety, the psychiatric aspects of chronic disability, rather than the physical needs, were perceived as stressful by caregivers. Psychological and behavioural factors related to caring for persons with Alzheimer’s disease, dementia, or both have been reported extensively. These factors were found to be of paramount importance in maintaining the health of individual caregivers (Jones & Martinson, 1992; Lindgren, 1993; Neundorfer, 1991; Pierce, Ader, & Peter, 1989). The authors basically agreed that the caregivers’ ability to cope with their own feelings and reactions was their major challenge and that failure to cope was the cause of instability.

Pearlin, Mullan, Semple, and Skaff (1990) stated that identifying factors that might be associated with stress or instability is not enough. Rather, attention must be focused on knowing how certain conditions develop and how they come to be related to each other; attention must also be given to the relationship among the many variables that lead to personal stress and the ways the relationship develop and change. Individual caregiver stress is a mix of circumstance, experiences, responses, and resources that vary considerably among caregivers and, consequently, vary in their impact on caregivers’ health and behaviour. According to Pearlin et al, a change in one of its components may result in changes in other; this mix is not stable. In the Framework of Systemic Organization, these statements are supported in that individual and family systems’ renewed well-being is interdependent.
Congruence: The research of Farran, Keane-Hagerty, Salloway, Kupferer, and Wilken (1991) is an example of well-being because it points to the need to understand the meaning of caring for another and the potentially positive outcomes for the caring person. Stability is provided by both the meaning of caring and positive outcomes of caring. The caregivers in this study valued their own feeling of confidence in that this motivated them to give good care. According to Davis and Grant (1994), caregivers with less than 6 months’ experience in the role reported having found personal meaning and purpose in the experience.

Three studies focused specifically on positive effects of caring by family caregivers. Evans, Bishop, and Ousley (1992), in interviewing family caregivers of stroke survivors, found that family relations seemed to be a source of strength. In a study of family caregivers of institutionalized elderly persons, Smith and Bengston (1979) reported three positive effects associated with the caring experience: renewed closeness and strengthening of family ties, continuation of closeness, and discovery of new love and affection. Silliman, Fajemilehin and Balogun (2009) stated that families of elderly persons with stroke had good feelings about themselves when they learned to manage the illness situation successfully. In fact, most families noted a closer relationship with the person who had a stroke because of the caring experience.

Nolan and Grant (1989) reported that satisfaction with caring, a component of stability, was evident in the majority of caregivers. A basic factor leading to satisfaction was the caregivers’ ability to protect their own psyche from negative self-perception and threatening emotions, such as guilt. At a higher level, this positive self-image proved a chance for personal development and an opportunity to better understand the human condition.

Furthermore, the maintenance of reciprocity in a relationship plays a major role in caregiver satisfaction (Nolan & Grant, 1989). In situations in which caregivers found some degree of satisfaction, the relationship seemed to be reciprocal in that, there was an element of return for the caregivers. This element did not necessarily signify a personal gain. Instead, the main source of satisfaction seemed to result from the act of giving to
the care recipients. These researchers found that satisfaction heightened for caregivers when it was clear that the recipients enjoyed themselves or maintained their dignity and self-esteem. Many caregivers reported that caring was embedded in a relationship in which they felt needed, useful, and productive. The study by Farran et al. (1991) also addressed interpersonal issues related to stability within the family. Caregivers valued positive aspects of relationship and of the caring situation in a family context. For example, positive family and social relationships, the recipients' love for the caregivers, and pleasant memories of others and their accomplishments were valued by the family caregivers. These caregivers also found meaning in the recipients' appreciation of, and positive responses to, the care provided.

In summary, caring has been seen as a nursing term/concept, including all the aspects that are used to deliver nursing care to patients. Sometimes caring has been conceptualized as a relational expression of human concern and as a collection of human activities that assists others. It is considered a universal phenomenon, which influence the ways in which people think, feel and behave towards one another. Caring is central to human expertise, to curing and to healing, and in the manner, meaning that it is the fundamental way of being in the world. As a word of being connected and having things matter works well because it fuses thought, feeling, and action-knowing and being coupled with determining what the patient cares about. The relationship based on whole being, concerns and projection for the individual which later provides motivation and direction, involves a moral commitment toward protecting human dignity and preserving humanity. Hence, caring within various theoretical perspectives, reflects a dual component, i.e. attitudes/values and activities. Therefore, caring can be explained as a process, an integration, which includes both motivation and behaviour, and has sometimes been conceptualized as a relational expression of human concern in the interrelationship of both ‘being’ and ‘doing’. More over, ‘being there’ is a kind of doing because it involves the nurse’s active presence and is not the same as just being attentive. ‘being with’ requires the nurse’s attention toward the patient and awareness of the nurse caring situation. Hence, it is truly a humanistic process in the dynamic relationship of an experiencing and reflecting human being in both ‘being and doing’ (figure 6).
In addition, caring is an intentional intervening interaction initiated out of the care-giver's and receiver's perceptions that something/someone is unwell, unsafe, at risk, or in need; the interaction is embodied in shared/mutual attitudes and feeling of concern for each other. It also refers to the level of emotional involvement between the care givers be it formal or informal and the client through seeking the client out, spending quality time with, providing emotional support, paying attention to needs or ensuring manipulative therapeutic actions. Hence, it is not only the bedrock of but the soul of nursing, what clients want, and need most from nurses. Meaning that, it is being there, willing, and able to nurture others. Hence, it is a
The hallmark of the effective and proficient nurse. Roberts (1990) discusses the hidden aspect of caring by saying, “The hidden part of caring reflects the care giver’s intent to preserve a person’s integrity during dignity-stripping, painful, and sometimes embarrassing situations”. It is during these situations that clients are least able to perform self care and thus, most need care. Thus, caring is more than an intuitive process which can be learned both intellectually and interpersonally. It is a process and an art that require commitment and knowledge. Caring is a combination of behaviours and attitudes demonstrated when nursing actions are implemented that expresses it be it at the informal or formal level. The totality of which determines the state of well being, outcome of illness and survival of illness trajectory.

**Trends in caring**

The traditional farming system in Africa that is well practiced among Yoruba people symbolizes a parameter that made polygamy and giving birth to many children a unique feature of the olden day’s African farmer. Resulting from such is the chain of social network around the elderly then and a positive position for caring and social support provision without stress which made familism to thrive (Fajemilehin and Ademola, 1999). The old have traditionally been honoured and respected. Religious texts and writings enjoined upon the male children to provide all support for their old parents. Grown-up children, especially sons, provided not only financial and material support for their parents; they also provided psychological and emotional support. Caldwell (1982) wrote: ‘It is a fallacy to think of the value of grown-up children being merely equivalent to an insurance policy against old age and sickness’. Like the commandment to ‘Honour thy father and thy mother’, there is a Sanskrit: mathru devabhava (mother is like God), pithru devabhava (father is like God), guru devabhava (teacher is like God). Those who neglected their old parents earned social opprobrium and were ridiculed. But there is already a saying, ‘mother has become poison and wife sweet’. Since Independence, ‘Nigeria’ like other African countries has been passing through a rapid socio-economic transformation which has brought about important changes in the social profile of the people.
The effect of socio-political and economic instability has not only weakened the natural bond but severed it. The effects of economic transition and conflict over two decades to now have been responsible for mass unemployment for youths who would have catered for the elderly and not leave them living in poverty and isolation, but there are few or none community-based services available to those who need support (Fajemilehin, 2000).

The role of family and other informal social network in meeting the needs and caring for frail elderly can not be overemphasized but has received very little attention in literature in this part of the world. Meaningful social relationship that provides a sense of security and opportunities for companionship and intimacy are important for the being of old people (Fajemilehin and Ade-Ademola, 2000). Among the frail elderly, that is people 70 years and above that are in weak state of health, reduced functional ability in performance of activities of daily living the opportunity for social contacts. Older people may experience diminished vitality and health at the same time as they experience relational losses, such as loss of a spouse, relatives and friends. Any or all of these situations may contribute to social isolation and loneliness. Life within the family also poses many problems. These problems are that of social relationship arising out of changing values, limited space, and state of family income and economic dependence of the elderly. Although, this social problems may affect physical health but more commonly they express themselves in strained relations, mental tensions, and a loss of interest in life.

In traditional Nigerian poverty eroding society, the aged knew no deprivation, malnutrition, neglect or isolation. The society was based on descent and kinship ties, which enhanced group solidarity and reverence for the elderly. The bond between children and parents was very strong thereby ensuring security in old age (Fajemilehin and Ade-Ademola, 2000). It was a cultural imperative for children to support and respect the elderly. The elderly could move freely among members of the extended family and be assured of the best of care. The social relationship and structure of the extended family was such that promoted closeness among members thus reducing the problem of isolation and loneliness among the elderly. The
elderly enjoyed a privileged position in the society and were accorded high status because of their knowledge and wisdom. They were respected for their knowledge of the laws and traditions of the society. Grandmother and father's concept has been part of Yoruba culture in promoting child development, care and education, contributing to family and community wellbeing. The above concept not only teach children important traditional values like empathy, solidarity with other family members, generosity and patience but use participatory adult learning methods for dialoguing and problem solving. The elderly took all the decisions concerning the governance of the society. Young members of the society looked to or sought advice from the elderly on important matter (Fajemilehin, 2000). The general situation that prevailed at that time and the care coupled with support which the elderly enjoyed made people to aspire to old age (5). Even when they had no surviving children they were sure that members of the extended family would give necessary support to alleviate their suffering (Fajemilehin et al, 1999, 2000, and 2003). Although traditional family values of respect for the elders and acceptance of responsibility for them to some extent still persist in developing countries, the changing social and economic context is raising new problems. The processes of modernization and urbanization as well as the introduction of local government administration have undermined the position of the aged in the Nigerian society. All the structural changes associated with these processes have made the aged powerless and left-out of the decision making process in the society. The aged now feel a loss of self-esteem as they do not fully participate in the social structure any more.

Modernization amidst poor leadership style and mismanagement had progressively weakened the extended family system and tradition that one should care for his aged parents is disregarded. Today, there are situations in which children abandon their aged parents. Some parents have lost contact with their children and do not know whether these children are alive or dead. In some cases, aged parents are abandoned because their children too are economically unable to support them. This neglect has created a lot of problems for the aged, especially those who have no incomes or pensions to support themselves. Some of them have turned into destitute roaming the streets and markets in the big cities begging for
food and money. Those of them who are still able to do some work earn incomes that are too small for the level of inflation in the country. Old age, which used to be a blessing is now characterized by insecurity and misery. In a society that has no formal structure of care and support for the elderly and there has been a consistent decline in the economy over a period of time. Effects of change as mentioned above had resulted in a marked weakness in the traditional extended family system in the society. Hence, there is a need to undertake more studies on the elderly with a view to determining what the elderly assessed as lacking familial needs, so as to be able to understand their situation against the background of change.

Transition of Care

Several studies from the developed countries have analysed the process of transition from home care or hospital care reported the roles of family in caring for relatives both in informal and formal settings and defined that nurses provide technical/professional care while the family members were assessed to provide preservative, social and emotional care. Family roles were limited by members’ inability to care and the dependency of the sick, while professional responsibility and accountability discouraged nurses from sharing some caring roles (Reed and Morgan, 1999; Reed and Roskell-Payton, 1999; Sharp, 1999; Assumpta and Hugh, 2000). Families consistently claimed greater responsibility for psycho-social tasks, but were willing to assume greater responsibility, particularly in areas of personal care and activities. Bowers (1988) observed that ability of the family members to provide the various levels of care was largely dependent on professional nurses’ co-operation. The above position contradicted the earlier studies’ finding (Litwak, 1981; Rubin and Shuttlesworth, 1983) that division of tasks was adopted to avoid conflict. Unfortunately, Brauer, Schmidt and Pearson (2001) further reported that family members expressed that professional nurses were not only failing to provide preservative care but also demonstrated unwillingness to collaborate. However, Assumpta and Hugh (2000) contrary to Brauer et al’s position found that the nurses expressed that they would like to see more of family members’ involvement in patients’ care.
It is observed with great concern that the Government of the nation has no focus measure in terms of policy, strategies or concept put in place for the changing aging process and its demographic implications to now. Aging group at the level of 60 years over be it working class or other wise are faced with changing world globalization, post-modernization confusion amidst the collapse of early traditional farming system which kept elderly surrounded by many wives and children and close range marital relations. Of importance today is the issue of the weakened state of extended family relationships and failed social support and care benefits from such. Today’s states of acculturation and post modernization confusion have left our cherished elderly ones in isolation devoid of familial attitude and care. To worsen the above state is the issue of youth unemployment which finally dashed the hope for financial attention, care and other support for their off-springs/children or other relationship (where the young rabbits itself has nothing to feed on, what hope for breast milk from them to the elderly ones. Regrettably is the fact that one out of every elderly ones is either widowed, economically obsolete without hope for the living, in hopelessness and extreme frustration waiting to die any time.

![Image](image_url)

**Figure 7**: Abandoned elderly found going around begging for arms.

64
The today’s scenario in Nigeria

The collapse of the traditional farming system, mass unemployment of youth and rapid urbanization had their resultant effects on finances, living, feeding and shortage of housing in towns and cities, and consequently in exorbitant house rents which act as a severe constraint on the common residence of the aged with their sons, especially, but not exclusively, for migrant families. In fact, the extended family system is gradually breaking down, giving way to the nuclear family system. Forces of modernization, technological changes and social mobility have changed people’s lifestyles and values. These changes have adversely affected traditional respect as well as attitudes of empathy and care for the elderly.

The migration of younger people from rural areas to towns and cities amidst civilization increases the vulnerability of the old who stay behind without familial support systems, particularly those living in families which do not have independent production sources like land, livestock or household industry and are dependent primarily on their labour. As a result of the acceptance of fertility control by an increasing proportion of couples, some of the elderly are likely to be given less care by their children because of increasing mobility, economic downturn and for other reasons.

The spread of education among women, accompanied by their employment outside the home in the offices and factories, leaves no time for those women to take care of old people at home. More important, there is now a greater investment by the family in the education and upbringing of children. The high cost of living, mass unemployment weakened extended family system and changing priorities, affect the intra-family distribution of income in favour of children. In this phraseology of Fajemilehin and Feyisetan, 2001, the wealth flow in Nigeria is turning downward. All these socio-economic changes have adversely affected the situation of elderly in Nigeria.

What is very important to me from the view of this lecture is that the summing up of the situation that Fajemilehin (2000) in his research efforts fully documented from the elderly respondents and in agreement with the popular Yoruba that says, “Ko si alajobi moo; alajogbe lo ku μ”. The
above is a result of social status of families today which is either poor or broken. A free style translation of this saying into English is: “There is no more consanguinity (alajobi) in the relationships of human beings: only (co-resident ship) alajogbe is left.” It is the root words ajobi and ajogbe of alajobi and alajogbe which I have unsatisfactorily but conveniently – translated into the English language as consanguinity and co-resident ship. Both are variations on the theme of association which two German sociologist at the turn of this country, had used to conceptualize what to me are two very significant matrices of interpersonal relationships: concord and conflict. To serve as a bridge between theses introductory remarks and the mainland of the ideas or discussions, I ask these questions: what is sociation? What are the defining characteristics of ajobi and ajogbe? Through what perspective of sociology can ajobi and ajogbe be regarded as variations on the theme of socialist?. Each person is now concerned with himself/herself and commitment of the past has faded away (olomun domun iya re gbe ni ile aye da nitoripe alajogbe loku alajobi ti tan pata). How do we explain graduation to executive joblessness and economic incapacitation of youth today?. Some of the factors made children not to be able to support their parents. What of the place of money in the elderly health, care and support as behaviourally being demonstrated (ihuwasi awon omo enia fi han pe owo ni ebi, ara ati ojulumo); if only money is what makes man, elderly without it will surely be at cross road (owo ko si enia ko sun won). Finally what of the negative of the nation’s present political and economic woes before the global as factors in the increased failure of family members to cater for their elderly ones (aye doju ru ko si oluto mo. Enyin omo Oduduwa nibo ni a nlo?). As I said a few seconds ago, I shall request all to ponder over it and relate to our individual experiences of today’s living relationship. Hence, who is there for the elderly care and support, who can the elderly count on for needs, the informal (family members that are now spatially separated) or the formal who lacks the necessary skill and other professional material resources for quality care maintenance. Surely, this is a pointer to a failure in the area of healthy ageing.
Figure 8: Abandoned elderly female in experience of destitution

Our responsibility as children

"honor your father and mother." (Ephesians 6:2; Exodus 20:12) with this simple yet profound quotation from the Hebrew Scriptures, the apostle Paul reminded children of the responsibility they have towards their parents. With Jehovah’s blessing, Joseph had become one of Egypt’s richest and most powerful men. (Genesis 41:40) but he did not consider himself too important or too busy to honor his 130-year-old father. What motivated Joseph to care for his father? While love and a sense of indebtedness to
the one who had given him life and who had nurtured him were factors, Joseph no doubt also felt a keen desire to please Jehovah. So should we. Paul wrote: “if any widow has children or grandchildren, let these learn first to practice Godly devotion in their own household and to keep paying a due compensation to their parents and grandparents, for this is acceptable in God’s sight.” (1 Timothy 5:4) Indeed, love for Jehovah and reverential fear of him will move us to care for ageing parents, no matter what challenges, doing so may involve.

The scenario of the elderly today is a serious negation of the adage of the old which says that the children are there as the insurance for the advanced elderly old to count on (meaning that bi okete ba dagba tan omun omo re ni maa mun). In the present day situation, it is the opposite to the extreme worse of experience that the elderly is the one involved in caring, catering, mending and sacrificing for the children till death. The resultant effects of the various negative home situations culminated to large number of elderly persons being found occupying acute hospital beds and or remaining in the hospital after discharge (Fajemilehin, Jinadu, Ojo and Feyisetan, 1996).

**Formal Care giving and Settings**

**Illness perspective**

In every culture, illness, the response to illness, the experience and treatment of illness, and the social institutions relating to illness are all systematically connected, but not uniformly patterned. Traditional health care is most of the time sought first by the sick individuals and his social networks while about 80% of the group not only consult traditional healers but combine both native medicine with hospital prescriptions in the course of hospitalization (Fajemilehin and Fabayo 1991). This means that the individual’s behaviour, style of thought and way of reacting to situations are influenced largely by the culture in which he lives. Reaction to situational stress during hospitalization will therefore vary from one person to another as a result of variation in each person’s cultural orientation (Fajemilehin and Fabayo, 1991).
The period of admission into hospital following illness is a stressful time requiring considerable attention. During hospitalization, apart from the strange surroundings, the smell and colours are not the same as at home, meals are served at specified and different times, there are new people to get used to. Whereas previously the patient belonged to himself and took care of his own bodily needs and functions, he is now a property to be cared for, fed, washed and cleansed. The patient's privacy is invaded and he must perform the most intimate functions in the presence of others even that most personal of all things, suffering, has to be experienced in an unfamiliar crowd (Fajemilehin and Fabayo, 1991).

Although, the hospital is expected to be equipped to deal with disease in a positive way, different hospital experiences, such as an uncertain atmosphere in the waiting room, conduction of several tests which unnecessarily pro-long the length of stay in the hospital, the negative attitude of hospital staff to patients demands, have caused many patients to assign negative connotations to hospital (Odebiyi, 1972; Fajemilehin and Fabayo, 1991). Today, majority of people are frightened when they are sick or ill and have to go to our hospitals. Some express the wish to die in peace at home rather than to go to one of these health care institutions to suffer humiliation or be treated as a second class citizen. This means that the process of recovery from illness is considered to be affected by the experience of stress. Hence, patronage of modern health care institutions will be a later taught when all other approaches of care fail.

The experience of being a patient

In a detailed study by Morrison (1994), an attempt has been made to understand patients further. Ten patients in a general hospital setting were interviewed to discuss:

- what the nurses did and how they did their work
- the type of relationship that developed between the nurses and the patients
- how patients perceived caring acts or caring individuals, and
- what, if anything, the patients gave to the nurses
An existential phenomenological approach was used to facilitate interviews which, on analysis, revealed a number of themes described as follows (Morrison, 1994):

- patients experienced crushing vulnerability
- patients adopted a particular mode of self-presentation
- patients evaluated the service provided in hospital
- patients’ personal concerns assumed great importance

As this is a recent study some of the detail associated with each of these themes will be highlighted here, not least because there are a range of findings which are positive and which reinforce many principles of effective care, but also there are many principles of effective care, but also there are many which highlight deficiencies in care which have been exposed before in a range of other studies.

**Crushing vulnerability**

The theme of crushing vulnerability appears as a major theme in this lecture. For some of the patients this experience is associated with a range of issues which include:

**The uncertainties**

- The uncertainty of how to behave and what to do in a strange hospital environment
- Trying to make sense of a situation and trying to analyse the behaviour of staff when diagnosis is unknown
- Lack of control over the situation
- ‘the shattering impact of cancer’
  
  (Fajemilehin and Fabayo, 1991; Morrison, 1994, p. 56)

**The feelings**

- feelings of being in hospital under duress
- feelings of fear about being in hospital
• feelings of being ‘treated like an object’ and needing some contact with trained staff
• being aware of the impersonal approach taken by staff
• feeling forgotten about
• feeling ignored during handovers process
• needing to cope with major changes in body image
• needing to know the truth
• feeling let down when an operation was canceled at the last minute.

The embarrassments
• the lack of privacy
• feeling like ‘a smelly mess compared with the nurses’ (the effects of faecal incontinence
• being talked about in front of other patients
• being dependent and needing help to use the toilet
• coping with a stoma.

The positive experience
• feeling valued as a person which contributed to feelings of well-being
• being called by their first name (acknowledging the detrimental effects of over-familiarity)
• the respect of personal wishes
• feeling hopeful despite the uncertainties of diagnosis and prognosis
• supportive nurse and doctors
• nurses who judged and responded to improving independence.
Reflective point

‘In the light of the experiences relating to crushing vulnerability, suggest ways that nurses may coordinate care in a way to reduce the negative experiences of illness coupled with hospitalization and promote the positive ones’.

In Morrison’s (1994) study, only one patient felt particularly critical of the care received. However, the experience of feeling like an object resulted from the lack of involvement in the care process and highlights the need for nurses to be sensitive to the situation that patients find themselves in. This is particularly important at times when crushing vulnerability may be experienced, for example, when there are uncertainties relating to diagnosis, when frightened and feeling isolated.

The model of self-presentation

It is suggested that patients cope with aspects of the hospital experience by presenting themselves in a particular way (Fajemilehin and Fabayo, 1991; Morrison, 1994). The strategies adopted by patients in the study included:

- becoming obedient and compliant
- conforming to ward rituals and routines
- putting on a brave face and becoming outwardly cheerful
- being honest and open with personal information
- supporting each other
- being reluctant to ask questions despite wanting answers
- needing to be up-to-date with information
- preferring to distance themselves from staff
- feeling that nursing staff ‘were not interested in, or supposed to get closer to, patients in hospital’
- trying not be a nuisance
• feeling they provided positive feedback to the staff
• showing gratitude to staff
• admiring the dedication of nursing staff.

The evaluation of hospital services

Perhaps the most significant findings here related to an overriding reluctance by patients to criticize staff. A range of reasons for this are suggested by Morrison (1994) including lack of status, reluctance to complain about care to those giving care, and lack of influence over decision making. While there appears to be general satisfaction with care, (Morrison, 1994; Fajemilehin, Adetayo and Monehin, 1998; Fajemilehin, 2000) state

The level of contact between professional carers and the patients did appear very limited.

There are no clear data given in the study on what proportion of nurses’ time is given to interacting with patients. However, patients did disclose that contact with registered nurses was limited to such occasions as the administration of medicines rather than nurse-initiated interaction. On the other hand patients appeared to conclude that despite many examples of positive care, sympathetic student nurses and approachable medical staff,

Several important criticisms also emerge that highlighted the need for staff to listen carefully to what patients have to say in order to evaluate nursing and medical care from the patients’ perspective (Morrison, 1994, p. 97).

Social dynamic model

• nurses identify themselves to the patient on first contact and make their responsibilities clear for better understanding
• in some places, nurses have adapted a ‘business card’ system to give to patients/other carers
• clear readable name badges are worn
the nurse’s name may be included on the bed notice, on medical and surgical records/in literature such as information books and letters about the ward service

the nurse may make copies of the duty rote available to patients, where appropriate, or details of these can be displayed clearly on notice boards

notice boards can be used to display names/photographs of nurses and groups of nurses they are responsible for

nurses clearly explain to patients who is caring for them, for example, at reporting and charge-over times, and ensure that time is planned in care for conversation and problem solving and so on for deep understanding coupled with the development of trust.

Of importance is the need to keep within the policy stipulated Nurse – Patient ratio

There are some of the matters considered where the complaint was justified

- Removal of lymph glands without formal consent during a mastectomy – unreassuringly response to complainant.
- Failure of hospital staff to give timely advice to relatives about assistance with funeral arrangements.
- Communication to relatives about a patient’s condition – lack of nursing care – a ward sister’s attitude – lack of support to relative when the patient died.
- Care of a disturbed elderly patient – inadequate supervision resulting in a fall – movement and treatment of a patient – health authority’s response to complaint.
- Delay in seeing a patient after a diagnosis of breast cancer and further delay in telling her of her diagnosis.
A right to consent

The notion of consent continues the theme of rights for individuals in relation to the right to know, and avoiding patients taking action which may result in compensation being sought. More so, in this day of health insurance with a legal string attached.

Tschudin (1992) suggests that there are four aspects of the consent process:

- Who may give consent
- The competency of the individual
- Who should provide the information
- The content of the information
- Who also the witness should be

Indicators of patient satisfaction with care

There are number of factors which contribute to the overall satisfaction that patients have with their care. Studies exploring satisfaction with medical care offer valuable insights which bear a marked resemblance to factors often highlighted as stressors by patients and emphasised by nurses, in particular the use of effective interpersonal skills, information-giving, listening and responding to personal concerns and the need for continuity of care (Fajemilehin and Fabayo, 1991; Fajemilehin, 2004). Clearly, McNeil (1988) and Fajemilehin and Fabayo, (1991) identified nine different dimensions of patient satisfaction and stressors. These are:

- the art of care
  technical quality
  accessibility
  convenience
  finance
  physical environment
  availability
• continuity
• outcome
• care setting surroundings
• noise on the ward
• the way each day is organized
• atmosphere in the ward
• visiting arrangements on the ward
• the clinical treatment that one receives
• the control of any pain
• nurses
• doctors
• radio, TV, day room for relaxation
• food
• telephones
• bathrooms and toilets
• overall, how satisfied are you with your hospital stay

According to Leninger (1981) caring in the nurse-client relationship is the direct or indirect nurturing and skillful activities, processes, and decisions related to assisting people to achieve or maintain health, meaning that caring will always happens within the care giver-care recipient relationship. Caring is being willing and able to nurture others in a process which occurs when a person acts in genuine, authentic manner with the client responding in a compassionate manner. It reflects the care giver’s intent to preserve a person’s integrity during dignity stripping, painful and sometimes embarrassing situations at the period the patient/client are least able to perform self care. It is more than an intuition process meaning that it can be learnt by both intellectually and interpersonally through interacting with others who demonstrate caring. Caring on its own is a combination of behaviour and attitudes in a process that requires commitment and knowledge in regular update.
The discipline of nursing

Nursing as a humanistic discipline is both an art and a science and a branch of knowledge ordered through the theories and methods evolving from more than one worldview of the phenomenon of concern that leads to therapeutic outcomes in clients. A professional discipline defined by its social relevance and value orientations derived from a belief and value system about the profession's social commitment, the nature of its service, and as area of responsibility for knowledge development. However, the discipline encompasses all that nursing is and all that nurses do, overlaps with other disciplines, and is more than the theory and research base. Therapeutic describes actions that are beneficial to the client. Nursing creates therapeutic change through the application of scientific principles. Therefore, nursing science is defined as the theoretical explanation of the subject of inquiry and the methodological process of attaining knowledge in a discipline; thus, science is both product and process which is arrived at through creative conceptualization and formal inquiry (Parse et al 2000). Hence, nursing is conceived a basic science, as the substantive discipline-specific knowledge that focuses on the human–environment–health process articulated in the nursing frameworks and theories. The discipline-specific knowledge resides within schools of thought that reflect differing philosophical perspectives that give rise to ontological, epistemological, and methodological process for the development of nursing's unique phenomenon of concern. As the science of nursing has rapidly progressed over the years, nurse theorists have formulated various frameworks by which to organize its body of knowledge. However, while continuing to expand its theoretical base, nursing must remain focused and or firmly rooted in its essence. This essence is caring coupled with nurturance which remains the bedrock of the art of the profession that all should embrace and continue to learn.

The Professionalisation of and Philosophical statement about Nursing

The nursing profession exists in response to a need of society and holds ideals related to man's health throughout his life span. Nurses direct their energies toward the promotion, protection or maintenance and
restoration of health, the prevention of illness, the alleviation of suffering and the ensuring of a peaceful death when life can no longer be sustained. Nurses value a holistic view of man and regard him as a bio-psychosocial* being who has the capacity to set goals and make decisions and who has the right and responsibility to make informed choices congruent with his own beliefs and values. Nursing; a dynamic and supportive profession guided by its code of ethic, is rooted in caring, a concept evident throughout its four field of activity: practice, education, administration and research.

Historically nursing as a profession, in the lay sense of the word, appears to have been socially accepted and generally accepted by other professions until the 1960s when questions arose from critics/sources inside and outside the profession as to the nature of its professional status. There were uncertainties about nursing roles, relationships with other professional groups within the National Health System, and doubts that the education of nurses was preparing them appropriately for registration.

Owing to the broad use of the terms; 'profession' and 'professional', it is necessary primarily, to establish interpretations of terms. Social scientists appear to have found analysis of the concept of a profession extremely difficult. The term implies respectability and status, but it has also been used to describe a job, occupation or work and, historically, has been appropriated by groups made up, almost exclusively, of men. This confusion is increased by the comparison of the terms 'professional' and amateur. However, despite the increase in occupations claiming professional status during the 1950s and 1960s (Etzioni, 1969), a defining feature is their collective orientation rather than self-orientation. The positive social force of a profession is widely accepted and this is perhaps the feature which allowed nursing its unchallenged position from Miss Nightingale’s era until the 1960s. Clarifying the features of nursing as a profession still further, it is interesting to utilize the trait approach. A traditional approach to the interpretation of an occupation as a profession is useful as part of the review of nursing as a profession. The list of traits by Brook (1974) centres on acceptably common attributes of a profession; which are as follows:
- the ideal of altruistic service
- practice based upon a foundation of theoretical, esoteric knowledge
- a long period of education (usually five years duration)
- control of entry and standards of practice
- An Organization—probably a professional council with disciplinary powers.

Professionalism is a process by which the characteristics of a profession are acquired, where the occupational associations control recruitment and practice and where there is marketable expert skill and knowledge. There is much controversy in the nursing literature about the value of the nurse acquiring professional status, indeed there is a range of writers who suggest that the development of professional power and activities may have a detrimental effect on those they serve (Schober and Hinchliff, 1995). However, Hall (1980) suggests that the Primary responsibility of nursing and therefore the purposes of professionalism is to provide direct care to the patient, client, family or community; it is concerned with maintaining, promoting and protecting the sick, and providing rehabilitation. It deals with the psychosomatic and psycho-social (and spiritual) aspects of life as these affect health, illness and dying (Hall, 1980, p. 153; King, 1968).

Hall and King suggested that:

Modern nursing is by no means limited to the giving of expert physical care to the sick, important though it is. It is more far reaching, including as it does helping the patient to unalterable situations such as personal, family and economic conditions, teaching him and others in the home and in the community to care for themselves, guiding him in the prevention of the illness through hygienic living and helping him to use available community resources to these ends. And King (1968) later defined nursing as a process of action, reaction, interaction and transaction whereby nurses assist individuals of any age group to meet their basic human needs in coping with their health status at some particular point in their life cycle.
Towards developing a Philosophy of nursing an exploration of Brink’s experience

One of the major strengths of nursing, the formal care of nature is its versatility, not just in its career opportunities, but also in its knowledge base. Just as nursing has developed its science from a number of supporting disciplines, nursing also has begun to acknowledge that science is not the only source of knowledge. We are also beginning to acknowledge that philosophy is as valid a way of knowing and understanding our universe as science, history, and personal experience. We have developed, and will continue to develop, our discipline through the blending of these seemingly disparate sources of knowledge (Brink, 2001).

In the philosophy of medicine, Pellegrino and Thomas (1981) explained that the essential component of medicine is the physician-patient relationship and that the focus, or central core, of that relationship is cure or healing. What brings a physician and patient together, the special or unique locus of the relationship, is cure or healing. How simple, and yet how profound!

This approach to a philosophy of medicine appeared to me to be sound, logical, and derived from the real world. The basic premise did not appear to be a fabrication of the authors’ minds. From that perspective, I turned to the notion of how I could apply this new knowledge to nursing. Could I take the same basic premise in examining my philosophy of nursing? Would it be as valid to say that the essential component of that relationship was care or caring?

Nursing does not exist without the patient/client Brink posited. Without that very special, unique association (the nurse-patient/client relationship) there would be no nursing discipline at all. The distinctive link between the nurse and patient/client, the unique locus of the relationship, is caring or care.

As a result of reading Pellegrino and Thomasmas, Brink thought again about our philosophies of nursing. Do we believe that the fundamental feature of nursing is the nurse-patient/client relationship? Do we agree that the most important and most integral aspect of that relationship is care
or caring? I wondered if our nurse-philosophers would agree with Pellegrino and Thomasmas. Nevertheless, I thought it an interesting point and one worth pursuing.

If the nurse-patient/client relationship is the central core of our philosophy of nursing, what aspects of the patient/client relationship do we value? Do we examine the patient/client’s perception of the situation, the context within which the interaction that affects the patient/client’s behaviour and feelings takes place? Do we examine the cultural beliefs of the patient/client and family in relation to the illness or disease process and its treatment and cure? Do we highlight the person who is ill, or threatened with illness, or do we focus upon ourselves?

If a philosophy of nursing were to focus upon the nurse-patient/client relationship, the context within which that relationship takes place, the cultural beliefs and values both nurse and patient bring to the situation, plus the caring dimension as the unifying theme underlying the relationship, what would that philosophy look like? Would it be different from what we have now? Would it arise from our collective experience and satisfy our concerns? Would it include the art of nursing as well as science? Would it be ethical? Would it be personally satisfying and appropriate? I wonder.

Any philosophy of nursing would have to struggle with the essence of nursing. In my opinion, it would have to include the nurse-patient/client relationship and care or caring. I am grateful to Pellegrino and Thomasmas for giving me a new insight, or a different way of looking at a familiar topic. On one hand, I knew before I read A Philosophical Basis of Medical Practice that the nurse-patient/client relationship existed, and I knew about care or caring, but I did not know in the same sense of knowing until I read their philosophy of medicine which the frame is as contained in figure 9. Hence, my gratitude
The multiple defining characteristics of health make it a complex issue along with needs, to maintain, achieve and to solve as problems. It implies a collective and multi-dimensional/professional responsibility to provide access to, considering quality, equity, power and scope (figure 10).
Figure 10: Dimensions of Care (adopted from Davies and O’Berle, 1990)
Due to the interwoven nature of the body and mind, it is impossible to separate physiological needs from psychosocial ones. For example, a person who is physically ill also experiences psychosocial disruptions. On the other hand, when a person is anxious or depressed, physiological manifestations occur. Hence, caregivers need to recognize this body-mind connection when caring for clients and patients. Caring being a universal value that directs familial support and practice be it formal and or informal in nature is as depicted in figure 4. Holism as it is frequently referred to in the context of individualized care which considers the biopsychosocial, spiritual and cultural needs of people needing nursing is therefore adopted to match the above descriptions. Many nurses however claim a holistic approach to caring without the requisite evidence that the individual is regarded as a whole. Hence, the American Holistic Nurses Association (1992) defines holism as the concept of wellness which comprised state of harmony between mind, body, emotions and spirit in an ever changing environment.

DEFINING THE THEORY OF A PRACTICE PROFESSION

When a social practitioner attempts to help a client, he is guiding to varying degrees by existing diagnostic and treatment procedures. These procedures are based in part on theories that state basic principles of effective practice.

The term practice theory is likely to suggest a conglomeration of beliefs, philosophical assumptions, and traditions that are used to guide or justify the actions taken by a professional on behalf of a client. Such a theory would contain many nonscientific components, including value assumptions whose truth or falsity could not be tested by research. This lecture will take a somewhat different approach to defining and analyzing the practice theory of a profession. The general definition of practice theory will include nonscientific theories, but will focus most of its attention on scientific practice theory. By scientific practice theory, I mean theory whose purpose is to predict the salient consequences of professional actions. Theories are scientific if their truth or falsity is determined by the results of empirical research, actions are professional if they involve the use of means over which the professions in question has autonomy, and consequences are salient if they involve goals for which the profession has responsibility.
To identify the boundaries of the scientific practice theory of a profession, I will analyze professional autonomy and responsibilities at these two different levels: (1) the authority of individual practitioners of the profession to decide when to use a given kind of treatment of diagnostic means and their accountability for outcomes and (2) the authority of profession to determine standards for practice procedures and its responsibility for carrying out the research necessary to evaluate their effectiveness. This analysis will itself be scientific and sociological rather than philosophical or ideological. In other words, I will make no statements about what the authority and responsibility of a given profession, such as nursing, should be. Instead, I will attempt to analyze the limits of professional authority and responsibility as objective aspects of existing social structure.

**Social Practice and Health Professional**

Health professionals such as doctors and nurses attempt to help their clients through social and psychosocial means in conjunction with physical means. When health professionals use social or psychosocial means in trying to help a client, they are engaging in social practice. Since social practice involves interaction between a social practitioner and his client, help provided on the basis of friendship, family ties, and the like is not included in our definition of the term. Thus, the behaviour of a nurse attempting to reassure a patient before an operation is regarded as social practice, provided that the help given can be considered part of her job, whereas identical behaviour on the part of a family member is not.

One can think of social practice as comprising two somewhat separate functions— I will refer to these functions as diagnosis and treatment, respectively, using these terms in a broader sense than usual. A nurse's attempts to calm a distraught patient or a social worker's advice not commonly viewed as treatment; yet in a broad sense they are treatment, that is, action taken by a practitioner in an effort to help a client. Similarly, what a social practitioner learns about a client in the process of friendly conservation is often relevant to the identification of client problems or the selection of effective means of treatment. Such interaction is therefore part of the diagnostic process. Almost all interaction between client and practitioner can be analyzed in terms of diagnosis or treatment. This does not mean that a practitioner's interaction with a client must be entirely a
means to an end but rather as something enjoyable in itself. It means that one important aspect of any interaction is its contribution toward the goals of social practice. It is the responsibility of the social practitioner to interact in a way that will promote the client’s welfare rather than reflect primarily the practitioner’s own preferences and desires.

This lecture therefore defines social practice in terms of a practitioner’s attempts to meet client needs by providing appropriate help. Not all client needs are served by any given kind of social practice, and not all means of treatment are appropriate for any given social practitioner to use. For example, if someone has a need to find a wife or to make money, he would not ordinarily seek help from a nurse or a physician.

**Nursing practice and the care of the hospitalized patient**

The goal of nursing practice has been defined by nursing theorists as helping the patient meet certain kinds of needs for help that he cannot meet for himself or scientific art of using knowledge of unitary human beings who are in mutual process with their environments for the well-being of people. (See, for example, Henderson, 1956; Orlando, 1961; and Weidenbach, 1964. Fawcett, 2004) The meeting of patients needs in the hospital is sometimes divided by social theorists into two separate diagnostic and treatment processes – patient care and patient cure – with the suggestion that nursing goals are primarily care goals and medical goals are primarily cure goals. Mauksch (1965) ties the distinction between care and cure to Harvey Smith’s classic essay (1955), “Two Lines of authority Are One Too Many.” Smith referred to a conflict between the two authorities of profession and bureaucracy, and although he thought of only the physician as a professional, the professional authority of the registered nurse comes no less in conflict with the bureaucratic authority of the administrative hierarchy of the hospital. In addition, the professional authority of the registered nurse can sometimes come into conflict with the professional authority of the physician.

**SOCIAL SUPPORT AND CULTURE**

The construct of social support encompasses broad theoretical frameworks and foci (Hupcey, 1998). This lecture is informed by the theoretical construction of social exchange theory (Gouldner, 1960), which posits social exchange based on the principle of equity, or balanced
exchange: People prefer and seek out relationships in which they give and receive more or less equal amounts of support (Antonucci, 1990). A discrepancy or imbalance in the exchange of support threatens the continuation of the relationship (Nuefeld & Harrison, 1995). This theory views social exchange to be contractual, with each individual an exchange agent and relationships maintained in part due to the personal benefit each individual receives from the interaction (Fajemilehin, 2000).

Recent cross-cultural research on social support is beginning to challenge the universality of the contractual social exchange model. The relationship assumptions and exchange norms of the Japanese group-oriented relationship model are an example of this problem. Within such a group-oriented model, personal benefits may not be the primary reason for affiliation, nor needs meeting the individuals needs may be the overriding concern. Rather, engagement within a group offers the benefit of security, despite the obligation of personal sacrifice. Nemoto (1998) studied social exchange norms in a sample of elderly Japanese in New York and found that received support required reciprocity. Furthermore, individuals experienced shame when asking for support outside of their close family. This is an Expression of the need for home care and support. In addition, Fajemilehin (2000) after a detailed meta-analysis posited that elderly persons continuously living with spouse or any other familial support are more likely to display positive health behaviour and in addition live longer. Those who valued these cultural and symptoms norms and were unable to reciprocate were more depressed, showed more symptoms of aging, and were less likely to feel satisfied with their lives than those who valued these cultural norms less. This finding is similar to that reported by Antonucci and Akiyama (1987) in which nonsymmetrical support exchanges in Japanese samples resulted in feelings of loneliness, dissatisfaction with relationships, and unhappiness.

Although these studies support the general concept of social exchange equity in Japanese culture, they challenge the fundamental assumptions about the nature of the social exchange relationship. They show that culture defines the dynamics of both the relationship and the exchange. The norms of reciprocity in these Japanese samples depend on the relationship context – that is, the norms are different if the exchange occurs with in-group or out-group members. Inequity in social exchange
did not result in the termination of relationships; individuals remained in their relationships but experienced depression, dissatisfaction, and shame. This lecture suggests the need for more studies on the relationship context of social exchange and the mechanisms by which social exchange is influenced between participants, obligations, and the social roles ascribed to various group affiliations.

**Caring Relationship within Caring Professions Model**

Figure 11: depicts a model or framework for Caring Relationships within Caring Professions. The caring relationship between the care-giver and care-receiver is different from the generic-caring relationship encountered in our daily lives. What distinguishes the caring relationship in a caring profession from other caring relationships is the presence of three critical factors: (1) the condition of need, (2) an attitude of concern, and (3) intentional involvement in intervention. What distinguishes it further is that all factors are present for the care-giver and receiver and are interactive:

![Diagram of the Caring Relationship within Caring Professions Model]

**Figure 11: caring relationship within caring professions model**

It is the interactive nature of the three factors which accounts for the development and enhancement of the caring relationship within caring professions. The dynamics of interaction is complex in that it involves the interaction of the three factors for each individual as well as between the individuals involved (the worker and the client(s)). It is the presence of
this dynamic that enhances the caring relationship as captioned in figure 11.

Before discussing the three factors and how they interact to create the caring relationship, it is important to point out the advantage of having a model which identifies key factors which account for the presence of caring. The identification of key factors allow for translations and differentiation across situations. In other words, while the key factors are identified, e.g., need(s), attitude of concern, and intentional interventions(s), the factors must be differentially defined or described for each situation at a particular point in time. The model permits then, indeed requires, the identification of different relationships appropriate to and congruent with the demands of the particular circumstances of the care-giver and care-receiver.

The advantage in this kind of model is that its application allows for different views based on different values which are related to culture, beliefs, theoretical orientations, etc., about what is happening. While the key factors mandate the conditions required to endure the presence of the caring relationship, they do not prescribe how the relationship must look, appear, or how the relationship must proceed to be caring; this is left to the discretion, creation and experience of the care-giver(s) and care-receiver(s).

ANALYZING THE KEY FACTORS IN THE CARING RELATIONSHIP WITHIN CARING PROFESSIONS CONTRACT MODEL

The factors in the model:

a) Condition of Need

The condition of need recognizes that the caring relationship attends to the personal needs of the child/youth family and to the professional needs of the professional worker. The condition of need defines the focus of care which in the case of the need child/youth/family is a condition of being unwell, unsafe, at risk, or in need. To attend to the need is to address whatever is missing in order for the particular child/youth/family to be in a state of well-being.
For the worker, the focus of care is to engage the child/youth/family in the caring relationship aimed at promoting the recreation of the child/youth/family’s well-being. While the focus of care, as defined by the needs for the two partners is different, the critical aspect for both partners is the recognition and acknowledgement of their need(s) and their mutual engagement in addressing their need(s). The model requires only that the focus of care be the need(s). It allows that different theoretical orientations, values, and beliefs about needs may be used, and does not prescribe any single, and by implication, “right thinking” or “politically correct,” orientation which must be applied. Examples of needs might include safety, self-image, behavioural skills, personal boundaries, family boundaries, new understanding, and so on.

b) Condition of Concern

The condition of concern refers to the attitudes and feelings of the care-giver and care-receiver. For the child/youth/family, the attitude is self-directed in that there is feeling/caring about the self and one’s own need(s). Further, the child/youth/family has feeling(s) for the caring relationship which is related to and expressed to the care-giver. Likewise, the care-giver has feeling(s) for the care-receiver and their relationship with each other.

This presence of concern and feeling takes professional caring into the personal realm and requires that both parties show up, be engaged at a feeling level for each other. The presence of feeling(s) provides the link which connects the worker and client. Very simply put, without this connection, without the feeling(s) in the relationship, the people do not matter to each other. It logically follows then, that if the people do not matter to each other, as evidenced, interventions would be pointless.

c) Intentional Intervention

The intentional involvement in intervention requires that the worker be thoughtful and have clarity of purpose in determining “what to do before doing it.” The worker does not randomly try out techniques in some mindless way hoping that something will work! The professional care giver uses
knowledge and skills to deploy a specific intervention designed to address the child/youth/family's needs. This professional involvement is about "doing with intention." The intentional involvement in intervention is what brings professionalism to the caring relationship. It presumes a body of knowledge, skills, and standards of practice recognized by workers and their professional colleagues.

The child/youth/family must also be involved in the intervention. However, in the case of the client, the involvement is about participation or being actively engaged in the intervention activities. The client's intention has more to do with commitment to being engaged in the activity rather than planning and implementing the activity.

Working from the model, what makes this model of caring within caring professions feminist in perspective, is the interactive component of attitude of concern(s), need(s) identification, and intentional intervention(s). The interaction that occurs between persons places an equal value on the individual needs of all players and their contribution with regards to what problems to solve and how to solve them. The caring relationship is one of partnership and the interaction within the caring relationship enhances the concern and ultimately the therapeutic relationship itself. The caring relationship is grounded in values of equity and communion, and values the specific and concrete over the abstract and reasonable.

In assisting man to achieve and maintain optimal health, nurses practice in a variety of settings and concurrently perform independent, interdependent and dependent functions. Nursing's unique independent contribution to health is made explicit through any one of the various conceptual models for nursing, each of which is a conception, that is, a way of looking at nursing sufficiently precise as to provide direction for practice education, administration and research. Interdependent functions are evident when nurses collaborate with other health-directed and health-related workers, whereas dependent functions are evident when nurses perform activities upon the direction of others, such as carrying out physicians' orders. The three overlapping functions all contribute to man's attainment of optimal health. Nursing exerts an influence on, and is influenced by, legislation governing or affecting the profession, and policies
and procedures in settings where nursing is practiced.

Nurses value the on-going discovery, acquisition, critical application and evaluation of relevant knowledge, attitudes and skills; these are prerequisites for the promotion of excellence in nursing practice, education, administration and research. In their search for excellence, nurses are committed to the development and implementation of standards for their own profession.

I have considered what constituted the essence of nursing. But what would 'essential nursing' look like in practice? Would it be any different to nursing as it is currently practiced in homes and wards up and down the country?

Nurses who have a deep understanding of those essential parts of their role would engage with the patient as a person first of all. They would decide how best to place the patient in the environment, in the situation most conducive for him or her to recover and feel better. If that means debating with colleagues over where patients should be located—whether it be a nursing home rather than a residential home, or a 'slow stream' rehabilitation unit rather than an acute medical ward—then that is what is required. They also have the skills necessary to evaluate the level of technical expertise required; they monitor each patient’s reaction to his or her illness or altered situation; they determine what information needs to be given, in what way and how frequently; and they set in motion a method by which each patient’s programme of care can be coordinated in a seamless, integrated person-centered and cost effective way as represented below in figure 12.
Figure 12: description of the 'essentials of nursing'
In this ideal world, a variety of nursing organizational systems would exist, appropriate to the needs of particular groups. For patients requiring straightforward, routine medical interventions with little invasive therapy, nursing care would focus on adequate information giving and technical assessment without the need for detailed or intensive interpersonal contact. Such care, typically carried out on a day case basis, requires competent nurses managing multi-skilled teams of competent medical technicians.

Contrast this situation to areas where patients will be unstable, volatile and highly dependent upon the skills and ability of nurses to monitor their physiological and psychological response to potentially life-threatening situations. The nursing role would be to ensure that the environment is adequately structured to deal with such levels of dependency and that all nursing staff have the necessary skill and competencies to anticipate and respond to sudden changes in the patient’s condition. Here, the need for whole teams of qualified nurses looking after small numbers of patients is what is required.

The number of skilled nurses to patients, the mix of nursing with medical technical skills, and the level of autonomy and control over the patient’s immediate environment, are all factors that have been found to be central to determining the quality of essential nursing care. Aiken et al (1994) and Kramer (1990) found that it was not necessarily the approach to organizing patient care that made it more effective, that is, whether it was task, team, primary nursing or care pathways. Rather, it was the most clinically (and cost) effective approach to care for a particular type of patient that led to the best care being given.

These are important principles to elucidate at this time, particularly when changes in the way medical care is being delivered are having a profound effect on nursing roles. The proliferation of specialist roles, with various titles such as ‘clinical nurse specialist’ or ‘nurse practitioner’ without the accompanying legal policy empowerment, changes in responsibility and authority for patient care, are developments which amount to pure economic waste in staff development need to be monitored carefully in the developing countries. Similarly, a recent research study carried out by the RCN (1997) into clinical nurse leadership, demonstrated how current
systems and structures in acute hospitals do promote effective nursing practice. Ward sisters no longer felt in control of their own work patterns and had to be coached to learn how to manage themselves. As a result of the study, ward leaders reported that they became self-aware, less defensive, open to criticism and more focused on delivering and improving the quality of patient care.

From this first step they were able to move to building and managing more effective relationships, and to develop new techniques to enable the nursing team to practice and monitor care that was more patient-centered. Communicating across wards and units and developing a more strategic approach to negotiating additional resources, were additional skills ward leaders developed.

These and similar findings indicate that effective patient-centered nursing requires not just the understanding of the essential elements of nursing, but also the ability to develop and use systems of care that protect it. One of the major problems facing nursing currently is the lack of regard for what nurses need in their systems and process to ensure good patient care.

**Communicating the essence of nursing**

The single greatest challenge for nursing is to be able to move from detailed descriptions of individual patients and their care, to outlining how such care is provided to groups of patients, and consequently how whole populations of patients could be provided with the same quality service. Such epidemiological-type thinking is not common in nursing: the emphasis has traditionally been on individuals and their immediate environment. Even public health nursing, which has more opportunity to engage in population needs assessment, has not refined such skills.

Nurse’s general inability to influence health policy and service delivery at the population level has been highlighted in some of the developed countries in connection with the commissioning debate (Antrobus and Brown 1997, Antrobus and Benson 1997). Nurses have had to be trained to be able to put their case in language and arguments that other health service managers would understand. Antrobus (1998) demonstrated how effective nurse leaders pick up the contrast skills and language in order to
argue effectively for what they need. She illustrated how these nurses have learnt how to communicate patient-centered care principles within a population-based framework using a case study approach. Nurses need to be more accomplished at communicating the power and contribution of nursing to health improvement. In the current climate of major health reforms, traditional systems of care delivery are being scrutinized both for their clinical and cost effectiveness. Nurses need to feel confident about their essential role and then begin to understand how delivery of these activities can be modified or improved to take account of wider social, economic and medical technological changes.

The most frequent topic for debate involves which tasks are nursing duties and what can be undertaken by healthcare assistants. Defensive reactions are no longer appropriate; there is no legitimacy in saying that such things should be done by nurses because they have always been done by nurses. Unless there is a good clinical reason based on the elements of patient-centered care and ensuring that the individual approach translates effectively into care for whole groups of patients – then nurses should be delegating tasks and ensuring an acceptable standard of care (Fajemilehin, 2004).

Redefining professional boundaries

In order to promote excellence in nursing practice, nursing may have to break out of the imagery of traditional professionalism (Davies 1995). Nursing, as a force for social welfare and improved health care in society, is most effective when it empowers and enables individuals, families and communities to take more control over their daily lives. As such, nurses operate in a way that is antithetical to most other professions. That is, nurses ought to be transferring their own nursing skills to the general population, ensuring that basic self-care skills are evident, caring for sick family members, having the right information, knowing where to go for additional support, and feeling confident about caring for sick relatives and friends.

The majority of care is still undertaken by relatives and or informal carers. This trend will continue. Nurse’s role is to ensure that, this vast
army of carers is properly supported and equipped to do a job that is fundamental to keeping society intact. Innovations in nursing care should centre on new partnerships with carers and patients, new ways of preventing health problems from arising and creative ways of tackling chronic health problems. In such a scenario the role of health-care assistants takes on a new meaning. They become agents of the local community, a resource and commodity, able to provide basic health information to families and friends coupled with assisting with the proposed elderly day care centres in our various local communities.

By acknowledging this wider health education role, nursing can free itself up to the point of undertaking the real job of promoting better health and wellbeing in a community-wide setting. Knowing how to set up such schemes, how to evaluate them, and how to lead and manage them, are all skills that need to be developed and refined. Changes in the delivery of health care enable these debates to take place: nursing needs to be ready to take on the challenge.

Redefining education

The challenge of course will go unheeded if there are insufficient nurses with specialised education, confidence and vision to know how to realize such opportunities. The move of nurse education into higher educational institution is welcome, but nurses need to know exactly how they are going to benefit from such developments. Nursing must embrace the challenge of academia and scholarship and demonstrate that the practical problems facing nurses in everyday practice do require the rigour and skill of scholarship to solve them properly.

The emphasis on evidence-based practice (Kitson, 1997; Fajemilehin, 2005) and the need to prepare more nurses capable of undertaking primary and applied research also reinforces the need for university-level education. To produce confident, articulate nurse leaders who understand the complexity of patient-centered care and who can construct systems of care for whole populations without compromising that individual focus is indeed a challenging and fulfilling requirement. That such capability is akin to other university-level activities is self-evident. Yet
this move to higher education does not detract from the need for nursing to attract a wide range of skills and intellectual abilities into the profession. With the philosophy of lifelong learning, nurse education needs to have the flexibility to enable a variety of skill to be utilized in preparing for registration. Thus, nursing should be widening the portals of entry to pre-registration preparation, creating a variety of vocational, work-based and academic routes—all connecting at the point of registration at graduate level. The most important message to communicate to the public and politicians is support the intension with the necessary political will and the reassurance that so-called ‘academics’ in nursing practice do not shift nursing practice emphasis away from essential patient-centered care. What we need to do is show how complex a job it is to sustain a person-centered approach to care and how we need to alter many of the processes and systems around us in order to get back to providing quality care to our patients. We need to invest in more clinical nurse leadership programme through which we can demonstrate exactly what the benefits are when nurses take charge of services providing the right environment in which patients can be cared for. These nurses will be leading multi-skilled nursing teams, serving groups of patients (possibly health problem-specific) working across boundaries, involving patients, carers, family members, the wider community in providing the correct support services.

Clinical leaders of this caliber will know how to evaluate the quality of such care and will ensure that all contributors are competent to undertake the job. They will also know how to liaise with other healthcare agencies such as GPs and specialist physician’s coordinating the care.

**Consequences**

The health care produced in such a future would be more informed and involve patients in decision making and promote partnership in care. Healthcare settings would be geared to meeting the needs of patients, they would be more integrated and care will be provided by a more satisfied, fulfilled and valued workforce. Whether this is a figment of one’s imagination, whether it is a possibility for the new millennium, we have to wait and see. Yet, some may feel that what has been described in these two segments is nothing more that the best examples of nursing care as it
has been practiced through the decades. This may indeed be the case and perhaps, the challenge to us all is to capture that which we know only obliquely and partially and try and make it more real. Perhaps our embracing of the future does reside in our understanding of the essences around us:

‘We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.’

CONCLUSION

Mr. Vice-Chancellor Sir, my colleagues, policy makers, governmental and non-governmental agencies and the University Community at large, it is often said that health is wealth. Moreover, that a state of complete health is never attainable, but health-illness continuum is constant interaction with care and support to make life and wellbeing to evolve. Hence, improved life span, a product of the above interaction gives rise to old age amidst successful culmination. This means that longevity is a product of successful health, caring and support interactionalism. Therefore, it would be my greatest pleasure if, as a result of what has been said in this lecture the problems of the elderly in the African community at large, and Nigeria in particular, can henceforth be better appreciated and addressed by all whose responsibility it is to promote and advance the course of the well-being of the elderly in Africa; if the suggested principles can prove useful; and if the prospects of the elderly in Africa can be maximally enhanced through healthy ageing promotion and protection by all. It is for this reason that this lecture is dedicated to all with special gratitude to My Creator and my late parents for protection, nurturance and successful orientation in life who have made this small beginning possible; my own teachers who have contributed to my academic growth; my clients (the elderly individuals across the globe), coupled with my family members and workmates, past and present, who have made their various contributions and have sacrificially dedicated their spare time, talents and services to properly assist me in the establishment of my focus.
My sincere thanks and appreciation go to the university authorities who have shown sufficient faith in me and the Department and have given us the wonderful opportunity to serve. It is my hope that we will all rededicate ourselves to the noble cause until the most original, relevant, comprehensive, effective and efficient elder-friendly programme is put in place for healthy-ageing promotion and protection among Africans and non-Africans, and for the benefit of not only Africans but humanity at large. Finally, I gratefully acknowledge the financial contributions of the Obafemi Awolowo University (U.R.C.) Ile-Ife, Social Science Academy of Nigeria, Ford Foundation, and the Government of Jamaica. Other support for this study was received from the West African College of Nursing, Nursing and Midwifery Council of Nigeria, and National Association of Nigerian Nurses and Midwives. Ladies and gentlemen, it is my sincere submission that care, coupled with adequate social support system is not only an essential need for good health and well being but a bed-rock of sustainable well-being of successful and active ageing, adding good years to life or longevity.

RECOMMENDATIONS:

Mr. Vice-Chancellor Sir, my colleagues, policy makers, governmental and non-governmental agencies and the University Community members here present, it is observed with great concern that the Government of the nation has no focused measure in terms of policy, strategy or concept put in place for the changing ageing needs and its demographic implications to now. Elderly group at the level of 60 years and over be it working class or otherwise are faced with changing globalization, post-modernization confusion amidst the collapse of early traditional farming system which kept the elderly surrounded by many wives and children and close range marital relations. Of importance today is the issue of the much weakened state of extended family relationships and failed social support and care benefits from such. Today’s states of acculturation and post modernization confusion have left our cherished elderly ones in isolation, devoid of familial attitude and care. To worsen the above state is the issue of youth unemployment which finally dashed the hope for financial attention, care and other support for their off-springs/children or other relationship (where the young rabbits themselves have
nothing to feed on, is there any hope for breast milk from them to the elderly ones? Regrettable is the fact that one out of every elderly ones is either widowed, economically obsolete without hope and in extreme frustration waiting to die any time.

Our youths today are busy watching videos of western culture, they are without concern and plans for their senior citizens who are either kept in semi-prison referred to as old people’s homes or could not afford to pay for assistances. Culture at this end will not permit such ugly separation from relations but benefit from elderly daycare centres created utilizing the community traditional halls with financial support from Government for transportation, feeding (3 times) and provision of indoor games facilities coupled with nanny concept as alternative.

Research focus is put on AIDS, but not on malaria and other non-communicable conditions that are killing people like chicken in Africa let alone on healthy aging or stable well being for the elderly. It is good to focus on reduction of maternal and child morbidity and mortality and concentrate effort on improved life span which will result in improved ageing without care, love and support. Hence, can we say we are happy with the state of elderly ones both retired and locally unemployed today compared with yesteryears and their levels of benefits to the served communities?

Rehabilitation Nursing for the Elderly Persons

After a period of illness many older patients may lose their ability to perform basic self-caring activities. This segment adopts the ESHUN-SMITH model to explain and describe the care given to older patients and anchor it with discharge preparation so as to ensure that elderly persons/patients outside hospital are sufficiently confident, independent and self-caring. The model spans all aspects of patient care, including the assessment of the individual’s needs on admission, the setting of care goals and the planning, implementation and evaluation of care with emphasis on promotion of self care by performing for themselves those activities of daily living that are considered critical or essential. The reason for subjecting the elderly and their social networks to rehabilitation is primarily to assist them to regain confidence in performing the critical or essential activities.
It has been observed that close to the period of discharge, many of the patients were anxious, and fearing that they may not be able to cope with meeting the critical needs. This contributes to the re-admission into hospital of many of the elderly for some social and or non-acute medical reasons indicating non-coping activity.

**PROTECTING, PRESERVING AND HONOURING THE AGED IN SOCIETY**

That most people want long, healthy and productive life is a truism. Where these aspirations are left entirely in the hands of individuals and their families, they may be difficult to attain. The United Nations Organization in recognition of the various forms of poverty often overtake the aged, prepared a programme on ageing in 1996 and even supports an International Institute on Ageing located in Malta. Global conferences are held periodically with various themes, to analyze the problems of the aged.

Even without internationally signed conventions, it stands to reason that governments should make conscious effort to take care of the aged in their domains – particularly those who have spent their youths and healthier periods in the service of their countries. Situation report from Nigeria revealed that, retired civil servants and even members of the armed forces are denied their pensions thereby forcing them to protest publicly and exposing themselves to danger, frustration and even sudden death for weeks. This is obviously unacceptable.

Hence, there is need to have a **national policy on the aged** in Nigeria so as to at least ensure:

- Prompt payment of gratuity on retirement and monthly pensions as and when due. The policy of requiring the pensioner to go and queue for payment must be modified for something more dignifying. Pension must also be sensitive to prevailing inflation in the society.
- Social services (like free intra town transportation, health care, adult education, etc.)
- Social security to ensure that the aged does not die of hunger.
- National awards and recognition.
Extension of mandatory retirement to 70 years.

Encouragement of the aged to be continuously engaged in social and economic activities in their environment thereby avoiding marginalization.

Non taxation of the aged (60 year and above)

Health and social services need to be integrated, coordinated and cost-effective through care by trained specialised nurses in the care of the elderly. as cataract surgery and hip replacements (health sector)

Credit schemes and access to small business and development opportunities so that older people can continue to earn a living or improve their earning capacity (governments and international agencies).

Changing the attitudes of health and social service providers is paramount to ensuring that their practices enable the empowered individuals to remain as autonomous and independent as possible for as long as possible. Professional caregivers need to respect older people’s dignity at all times and to be careful to avoid premature interventions that may unintentionally induce the loss of independence.

Researchers need to better define and standardize the tools used to assess ability and disability and to provide policy makers with additional evidence on key enabling processes in the broader environment, as well as in medicine and health. Careful attention needs to be paid to gender differences in these analyses.

Challenges of providing free health Care services for ageing Populations

As population age, one of the greatest challenges in health policy is to strike a balance among support for self-care (people looking after themselves), informal support (care from family members and friends), and formal care (health and social services). Formal care includes both primary health care (delivered mostly at the community level) and institutional care (either in hospital or Day care centres). While it is clear that most of the care individuals need is provided by themselves or their
informal caregivers, most countries allot their financial resources inversely, i.e., the greatest share of expenditure is on institutional care. The policy framework requires action on three basic pillars:

**Health.** When the risk factors (both environmental and behavioural) for chronic diseases and functional decline are kept low while the protective factors are kept high, people will enjoy both a larger quantity and quality life, they will remain healthy and able to manage their own lives as they grow older; fewer older adults will need costly medical treatment and care services. Of importance is the urgent need by way of policy to include them in the National Health Insurance Scheme.

For those who do need care, they should have access to the entire range of health and social services that address the needs and rights of women and men as they age.

**Participation.** When labour market, employment, education, health and social policies and programmes support their full participation in socio-economic, cultural and spiritual activities, according to their basic human rights, capacities, needs, and preference, people will continue to make a productive contribution to society in both paid and unpaid activities as they age.

**Security.** When policies and programmes address the social, financial and physical security needs and rights of people as they age, older people are ensured to protection, dignity and care in the event that they are no longer able to support and protect themselves. Families and communities are supported in efforts to care for their older members.

**Inter-sectoral Action**

Attaining the goal of active ageing will require action in a variety of sectors in addition to health and social services, including education, employment and labour, finance, social security, housing, transportation, justice and rural and urban development. While it is clear that the health sector does not have direct responsibility for policies in all of these other sectors, they belong in the broadest sense within the scope of public health because they support the goals of improved health through inter-sectoral action.
This kind of an approach stresses the importance of the numerous different public health partners and reinforces the roles of the health sector as a catalyst for action.

An active ageing approach seeks to eliminate age discrimination and recognize the diversity of older populations. Older people and their caregivers need to be actively involved in the planning, implementation and evaluation of polices programmes and knowledge development activities related to active ageing.

**Key Policy Proposal**

The following policy proposals are designed to address the three pillars of active ageing: health, participation and security. Some are broad and encompass all age groups while others are targeted specifically to those approaching old age and/or people themselves.

1. **Health**

1.1 **Prevent and reduce the burden of excess disabilities, chronic disease and premature mortality.**

- **Goals and targets.** Set gender-specific, measurable targets for improvements in health status among older people and in the reduction of chronic diseases, disabilities and premature mortality as people age.

- **Economic influences on health.** Enact policies and programmes that address the economic factors that contribute to the onset of disease and disabilities in later life (i.e., poverty, income inequities and social exclusion, low literacy levels, lack of education). Give priority to improving the health status of poor and marginalized population groups.

- **Prevention and effective treatments.** Make screening services that are proven to be effective, available and affordable to women and men as they age. Make effective, cost efficient treatments that reduce disabilities (such as cataract removal and hip replacements) more accessible to older people with low incomes.
Age-friendly, safe environments. Create age-friendly health care centre and standards that help prevent the onset or worsening of disabilities. Prevent injuries by protecting older pedestrians in traffic, making walking safe, implementing fall prevention programmes, eliminating hazards in the home and providing safety devices and advice. Stringently enforce occupational safety standards that protect older workers from injury. Modifying formal and informal work environments so that people can continue to work productively and safely as they age.

Hearing and vision. Reduce avoidable hearing impairment through appropriate prevention measures and support access to hearing aids for older people who have hearing loss. Aim to reduce and eliminate avoidable blindness by 2020 (WHO, 1997). Provide appropriate eye care services for people with age-related visual disabilities. Reduce inequities in access to corrective glasses for ageing women and men.

Barrier-free living. Develop barrier-free housing options for ageing people with disabilities. Work to make public buildings and transportation accessible for all people with disabilities. Provide accessible toilets in public places and work place.

Quality of life. Enact policies and programmes that improve the quality of life of people with disabilities and chronic illnesses. Support their continuing independence by assisting with changes in the environment, providing rehabilitation services and community support for families, and increasing affordable access to effective assistive devices (e.g., corrective eyeglasses, walkers).

Social support. Reduce the risk of loneliness and social isolation by supporting community groups run by older people, traditional societies, self-help and mutual aid groups, peer and professional outreach programmes, neighbourhood visiting, telephone support programmes, and family caregivers. Support intergenerational contact and provide housing in communities that encourage daily social interaction and interdependence among young and old.
• **HIV and AIDS.** Remove the age limitation on data collection related to HIV/AIDS. Assess and address the impact of HIV/AIDS on older people, including those who are infected and those who are caring for others who are infected and/or for AIDS orphans.

• **Mental health.** Promote positive mental health throughout the life course by providing information and challenging stereotypical beliefs about mental health problems and mental illness.

• **Clean environments.** Put policies and programmes in place that ensures equal access for all to clean water, safe food and clean air. Minimize exposure to pollution throughout the life course, particularly in childhood and old age.

1.2 Reduce risk factors associated with major diseases and increase factors that protect health throughout the life course.

• **Tobacco.** Take comprehensive action at local, national and international levels to control the marketing and use of tobacco products. Provide older people with help to quit smoking.

• **Physical activity.** Develop culturally appropriate, population-based information and guidelines on physical activity for older men and women. Provide accessible, pleasant and affordable opportunities to be active (e.g., safe walking areas and parks). Support peer leaders and groups that promote regular, moderate physical activity for people as they age. Inform and educate people and professionals about the importance of staying active as one grows older.

• **Nutrition.** Ensure adequate nutrition throughout the life course, particularly in childhood and among women in the reproductive years. Ensure that national nutrition policies and action plans recognize older persons as a potentially vulnerable group. Include special measures to prevent malnutrition and ensure food security and safety as people age.
Healthy eating. Develop culturally appropriate, population-based guidelines for healthy eating for men and women as they age. Support improved diets and healthy weights in older age through the provision of information (including information specific to the nutrition needs of older people), education about nutrition at all ages, and food policies that enable women, men and families to make healthy food choices.

Oral health. Promote oral health among older people and encourage women and men to retain their natural teeth for as long as possible. Set cultural appropriate policy goals for oral health and provide appropriate oral health promotion programmes and treatment services during the life course.

Psychological factors. Encourage and enable people to build self-efficacy, cognitive skills such as problem-solving, pro-social behaviour and effective coping skills throughout the life course. Recognize and capitalize on the experience and strengths of older people while helping them improve their psychological well being.

Alcohol and drugs. Determine the extent of the use of alcohol and drugs by people as they age and put practices and policies in place to reduce misuse and abuse.

Medications. Increase affordable access to essential safe medications among older people who need them but cannot afford them. Put practices and policies in place to reduce inappropriate prescribing by health professionals and other health advisors. Inform and educate people about the wise use of medications.

Adherence. Undertake comprehensive measures to better understanding and correct poor adherence to therapies, which severely compromise treatment effectiveness, particularly in relation to long-term therapies.

1.3 Develop a continuum of affordable, accessible, high quality and age-friendly health and social services that address the needs and rights of women and men as they age.
A continuum of care throughout the life course. Taking into consideration their opinions and preferences, provide a continuum of care for women and men as they grow older. Re-orient current systems that are organized around acute care to provide a seamless continuum of care that includes health promotion, disease prevention, the appropriate treatment of chronic diseases, equitable provision of community support and dignified long-term and palliative care through all the stages of life.

Affordable, equitable access. Ensure affordable equitable access to quality primary health care (both acute and chronic), as well as long-term care services for all.

Informal caregivers. Recognize and address gender differences in the burden of caregiving and make a special effort to support caregivers, most of whom are older women who care for partners, children, grandchildren and others who are sick or disabled. Support informal caregivers through initiatives such as respite care, pension credit, financial subsidies, training and home care nursing services. Recognize that older caregivers may become socially isolated, financially disadvantaged and sick themselves, and attend to their needs.

Formal caregivers. Provide paid caregivers with adequate working conditions and remuneration, with special attention to those who are unskilled and have low social and professional status (most of whom are women).

Mental health service. Provide comprehensive mental health services for men and women as they age, ranging from mental health promotion to treatment services for mental illness, rehabilitation and re-integration into the community as required. Pay special attention to increased depression and suicidal tendencies due to loss and social isolation. Provide quality care for older people with dementia and other neurological and cognitive problems in their homes and in residential facilities when appropriate. Pay special attention to ageing people with long-term intellectual disabilities.
Coordinated ethical system of care. Eliminate age discrimination in health and social services systems. Improve the coordination of health and social services and integrate these systems when feasible. Set and maintain appropriate standards of care for ageing persons through regulatory mechanisms, guidelines, education, consultation and collaboration.

Iatrogenesis. Prevent iatrogenesis (disease and disability that is induced by the process of diagnosis or treatment). Establish adequate systems for preventing adverse drug reactions with a special focus on old age. Raise awareness of the relative risks and benefits of modern therapies among health professionals and the public at large.

Ageing at home and in the community. Provide policies, programs and services that enable people to remain in their homes as they grow older, with or without other family members according to their circumstances and preferences. Support families that include older people who need care in their households. Provide help with meals and home maintenance, and at-home nursing support when it is required.

Partnerships and quality care. Provide a comprehensive approach to long-term care (by informal and formal caregivers) that stimulates collaboration between the public and private sectors and involves all levels of government, civil society and the not-for-profit sector. Ensure high quality standards and stimulating environments in residential care facilities for men and women who require this care, as they grow older.

1.4 Providing training and education to caregivers.

Informal caregivers. Provide family members, peer counselors and other informal caregivers with information and training on how to care for people as they grow older. Support older healers who are knowledgeable about traditional and complementary medicines while also assessing their needs.
Formal caregivers. Educate health and social service workers in enabling models of primary health care and long-term care that recognize the strengths and contributions of older people. Incorporate modules on active ageing in medical and health curricula at all levels. Provide specialist education in gerontology and geriatrics for medical, health and social service professionals.

Inform all health and social service professionals about the process of ageing and ways to optimize active ageing among individuals, communities and population groups. Provide incentives and training for health and social service professionals to support self-care and counsel healthy lifestyle practices among men and women as they age. Increase the awareness and sensitivity of all health professionals and community workers of the importance of social networks for well being in old age. Train health promotion workers to identify older people who are at risk for loneliness and social isolation.

2. Participation

2.1 Providing education and learning opportunities throughout the life course

Basic education and health literacy. Make basic education available to all across the life course. Aim to achieve literacy for all. Promote health literacy by providing health education throughout the life course. Teach each people how to care for themselves and each other as they get older. Educate and empower older people on how to effectively select and use health and community services.

Lifelong learning. Enable the full participation and programmes in education and training that support lifelong learning for women and men as they age. Provide older people with opportunities to develop new skills, particularly in areas such as technologies and new agricultural techniques.

2.2 Recognizing and enabling the active participation of people in economic development activities, formal and informal
work and voluntary activities as they age, according to their individual needs preferences and capacities.

**Poverty reduction and income generation.** Include older people in the planning, implementation and evaluation of social development initiatives and efforts to reduce poverty. Ensure that older people have the same access to development grants, income-generation projects and credit as younger people do.

**Formal work.** Enact labour market and employment policies and programmes that enable the partition of people in meaningful work as they grow older, according to their individual needs, preferences and capacities (e.g., the elimination of age discrimination in the hiring and retention of older workers). Support pension reforms that encourage productivity, a diverse system of pension schemes and more flexible retirement options (e.g., gradual or partial retirement).

**Informal work.** Enact policies and programmes that recognize and support the contribution that older women and men make in unpaid work in the informal sector and in caregiving in the home.

**Voluntary activities.** Recognize the value of volunteering and expand opportunity to participate in meaningful volunteer as people age, especially those who want to volunteer but cannot because of health, income, or transportation restrictions.

2.3 **Encouraging people to participate fully in family community life, as they grow older.**

**Transportation.** Provide accessible, affordable transportation services in rural and urban areas so that older people (especially those with compromised mobility) can participate fully in family and community life.

**Leadership.** Involve older people in political processes that affect their rights. Include older women and men in the planning, implementation and evaluation of locally based health and social
service and recreation programmes. Include older people in prevention and education efforts to reduce the spread of HIV/AIDS. Involve older people in efforts to develop research agenda on active ageing, both as advisors and as investigators.

A society for all ages. Provide greater flexibility in periods devoted to education, work and caregiving responsibilities throughout the life course. Develop a range of housing options for older people that eliminate barriers to independence with family members, and encourage full participation in community and family life. Provide intergenerational activities in schools and communities. Encourage older people to become role models for active ageing and to mentor young people. Recognize and support the important role and responsibilities of grandparents. Foster collaboration among non-governmental organisations that work with children, youth and older people.

A positive image of ageing. Work with groups representing older people and the media to provide realistic and positive images of active ageing, as well as educational information on active ageing. Confront negative stereotypes and ageism.

Reduce inequities in participation by women. Recognize and support the important contribution that older women make to families and communities through caregiving and participation in the informal economy. Enable the full participation of women in political life and decision-making positions as they age. Provide education and lifelong learning opportunities to women as they age, in the same way that they are provided to men.

Support organizations representing older people. Provide in-kind and financial support and training for members of these organisations so that they can advocate, promote and enhance the health, security and full participation of older women and men in all aspects of community life.
3. **Security**

3.1 **Ensuring the protection, safety and dignity of older people by addressing the social, financial and physical security rights and need of people as they age.**

**Social security.** Support the provision of a social safety net for older people who are poor alone, as well as social security initiatives that provide a steady and adequate stream of income during old age. Encourage young adults to prepare for old age in their health, social and financial practices.

- **HIV/AIDS.** Support the social, economic and psychological well being of older people who care for people with HIV/AIDS and take on surrogate parenting roles for orphans of AIDS. Provide in-kind support, affordable health care and loans to older people to help them meet the needs of children and grandchildren affected by HIV/AIDS.

- **Consumer protection.** Protect consumers from unsafe medications and treatments, and unscrupulous marketing practices, particularly in older age.

**Social justice.** Ensure that decisions being based on the rights of older people and guided by the UN principles for Older Persons. Uphold older person’s rights to maintain independence and autonomy for the longest period of time possible.

- **Shelter.** Explicitly recognize older people’s right to and need for secure, appropriate shelter, especially in times of conflict and crisis. Provide housing assistance for older people and their families when required (paying special attention to the circumstances of those who live alone) through rent subsidies, cooperative housing initiatives, support for housing renovations, etc.

**Crisis.** Uphold the rights of older people during conflict. Specifically recognize and act on the need to protect older people in emergency situations (e.g., by providing transportation to relief centres to those who cannot walk there). Recognize the
contribution that older people can make to recovery efforts in the aftermath of an emergency and include them in recovery initiatives and avoid destitution.

- **Elder abuse.** Recognize elder abuse (physical, sexual, psychological, financial and neglect) and encourage the prosecution of offenders. Train law enforcement officers, health and social service providers, spiritual leaders, advocacy organizations and groups of older people to recognize and deal with elder abuse. Increase awareness of injustice of elder abuse through public information and awareness campaigns. Involve the media and young people, as well as older people in these efforts.

- **3.2 Reduce inequities in the security rights and needs of older women.**

  - Enact legislation and enforce laws that protect widows from the theft of property and possessions and from harmful practices such as health-threatening burial rituals and charges of witchcraft.

  - Enact legislation and enforce laws that protect women from domestic and other forms of violence as they age.

  - Provide social security (income support) for older women who have no pensions or meagre retirement incomes because they have worked all or most of their lives in the home or informal sector.

**International Collaboration**

With the launch of the International Plan of Action on Ageing, the 2002 World Assembly on Ageing marks a turning point in addressing the challenges and celebrating the triumphs of an ageing world. As the Agency embarks on the implementation phase, cross-nation, regional and global sharing of research and policy options will be critical. Member states, non-governmental organizations, academic institutions and the private sector being called upon to develop age-sensitive solutions to the challenges of an ageing world with necessary political will for its successful implementation. They will need to take into consideration the consequences of the epidemiological transition, rapid changes in the health sector,
globalization, urbanization, changing family patterns and environment degradation, as well as persistent inequalities and poverty, particularly in developing countries where the majority of older people are already living.

Action on all three pillars of active ageing needs to be supported by knowledge development activities including evaluation, research and surveillance and the dissemination of research findings. The results of research need to be shared in clear language and accessible and practical formats with policy makers, non-governmental organizations representing older people, the private sector and the public at large.

**Issues of concern to the lecturer on Elderly Health and Quality of Life today in Nigeria are as itemized:**

1) Elderly survival in the past rested mostly on polygamy, family and traditional farming-concepts of many wives and children who are all around the aged for all needs, supports and care while the recognition of the elderly gatherings promoted their dignity and pride.

2) Westernization/Education etc. eroded the tie of unity and strength of the above in 1. Living them without the necessary support, care and respect. Weakening the informal structure of care/support in place. Hence, older people remain disproportionately poor, discriminated against and socially excluded because they have limited capacity to earn a living. Furthermore, family support systems are being eroded by the rural urban migration of younger generations.

3) Economic technology-aged are mostly unable to work like others and the few that are in employment are readily retired, and leaving them without financial security.
Figure 13: An elderly female looking forward to care and support for improved living condition

1) Ageing process put on the elderly a level of degenerative changes proving them to several levels of chronic illness/ailments.

2) Governments has not seen the need for priority attention for the age subgroups and hence are without any formal structure of care, support and welfare attention.

3) Health policy-today to the best of anybody’s knowledge, there is no gerontology and geriatric clinic put in place. Of serious concern is the fact that all health professional curricula lack gerontologic concepts, a reason for the poor interest of the professionals to working with the elderly (Fajemilehin, 2004):
4) Demographic change: Health technology and adjustment to medical care have caused people to grow older. Not less than 8% of the population today are 60 and above. About 12-15% is between 45 and 59 years. In 1990 census, if it is anything to come by

8) Population of elderly now ranged between 6-12% by year 2005 against the background of financial obsolescence, lack of formal care, collapse of the informal extended familial structure, isolation, boredom and chronically immeasurable health conditions.

9) Hence, if clinics are opened, such clinics will only becomes screening centres for

   a) Each will require multidimensional attention and needs
   b) Chronic illness will require surgery and attention which will cost much money that the sub group cannot afford.
   c) Prescriptions will never be bought for lack of funds.
   d) No one is prepared to specialize in the area because it does not generate fund but consumes fund. Of negative consideration is the fact that funding of any research proposal with a focus on the health of this subgroup is never of priority to any agency compared with HIV/AIDS, MATERNAL and CHILD and other related issues.

Social commitment - losses in terms of lives, spouses, children, immobility, lack of strength, funds, and healthy food items due to cost, isolation, transportation and familial persons to assist with food preparation. Hence, all put together remained terrible hard nuts to crack for both health personnel and the elderly persons.

10) THE WAY FORWARD:

    Reorganization of families to their formal levels of structure through promotion of family union and extended family relationship;
Encouraging positive old cultural concepts and rural development (traditional farming system), strengthening grandmothers/fathers’ role in the care and education of children on the importance of traditional values and provision of infrastructure (small scale industries) to reduce drift from rural to urban centres;

Day Care approach for the elderly utilizing family compound facilities (to include transportation, feeding, in and door games through the cooperation of both the State and Local government;

Putting formal structure of care in place such as gerontology and geriatric clinics and services at Primary Health Care levels (PHC) coupled with Day Care facilities;

Attention to Nutritional needs of the elderly;

Policy on health promotion strategies for the elderly;

Promotion and support for strategies that will re-unite the already weakened or more or less collapsed extended family ties (the only source of in-formal care and support for the elderly). Access to such health care facilities should be improved upon couple with help with transport, older people’s association or club to promote psychosocial support;

Promotion and support for intervention research that will focus on improving the economic earnings and promote the well being of the elderly;

Inclusion of gerontologic contents in all curricula of students of health professions; and

Special funding of health research proposals on the elderly.

Promoting more elderly relaxation centres for practice of tradition i.e. Kabbala centre Ile-Ife.
Figure 14: Traditional elderly relaxation centre (YORUBA KABBALA FAMILY) showing some members.

I thank you for your patience and attention.
REFERENCES


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Caring involves both love and labour, and it is precisely this combination that underlines its conceptual complexity (Finch & Groves, 1983).
• Caring is human service work—“people work”—but it has not been recognized as work (Pascall, 1986).
• Caregiving is an activity encompassing both instrumental and affective relations (Abel & Nelson, 1990).
• Caring is a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible.
• Caring can be seen as a process of four intertwining phases: caring about, taking care of, caregiving, and care-receiving (Fisher & Tronto, 1990).
• Caring is achieved through conscious judgment and www.frc.mass.edu/sconrad/conceptual_terms.htm


Stuck, Walthert, Nikolaus, Bula, Hohmann and Beck (1999)


