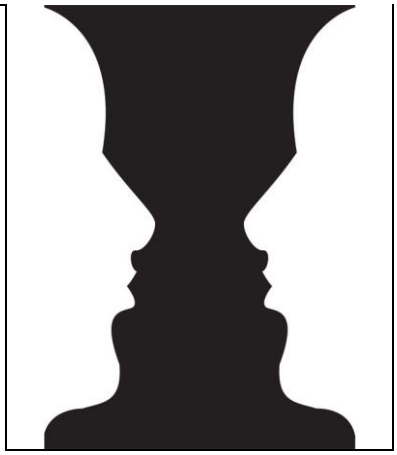
JOURNAL OF COMPARATIVE RESEARCH IN ANTHROPOLOGY AND SOCIOLOGY

Volume 1(1): 107-120
ISSN 2068 – 0317
http://compaso.ro



Gender perspectives in self-assessment of quality of life of the elderly in South-Western Nigeria

Are there variations in quality of life among ageing men and women?

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Abstract
This study examined gender variations in self reported quality of life among randomly selected elderly populations in selected Yoruba communities in three local government areas of Osun State Nigeria. Data was generated through cross-sectional survey of 947 elderly population aged 60 years and above. Two internationally tested instruments were used to assess quality of life status among the respondents- Activities of Daily Life (with 14 items scales) (ADL) and Aging Male Symptoms (AMS) (with 17 items scales and adapted for both males and females). Findings showed that elderly female fared better than the male counterparts on some of the measures. Also, females were more likely than their spouse to be able to cope without any assistance. Results from males with a living spouse showed that majority of the spouse (females) were more likely to need assistance for usual daily activities compared with the male (husband). This trend was also confirmed among female respondents as a fewer proportion of spouse (male) can cope without any help compared with females. The AMS showed that male reported a better health status in the domains of sexual, psychosocial and somatic measures. The study concluded that measures of quality of life were likely to favour elderly females than males because of many challenges and responsibilities of males. The study raised the need for more in-depth studies to investigate the role of social –cultural factors of male dominance and patriarchal system on quality of life of the elderly from the gender lens.

Keywords
Gender, quality of life, Nigeria

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Introduction

Ageing process has been generally viewed as a homogenous process. Studies have construed the ageing situation as one that shared common characteristics without recourse to the gender dimension to it. Particularly in developing countries like Nigeria with major issues affecting both males and females uniquely, the situation in old age may therefore represent a form of cumulative effects of events in the past. For instance, Nigeria is a patriarchal society with major male dominance and male preference. Polygamous marriage is a common feature in Nigeria where men can marry multiple wives. Divorced, separated or widowed women are viewed with cultural disdain and may be subjected to social denial in some cases. Many of these social roles have different impacts on both males and females differently, particularly in old age and may influence health outcomes.

The self assessment of the quality of life of the elderly from gender perspective is highly imperative in understanding male and female health issues. The health challenges of the elderly cannot be over-emphasized, particularly in environment with poor health system and acute lack of geriatrics care. It is an area that has not been adequately attended to in Nigeria. Health-care practice and utilization need a comprehensive understanding of the health needs of the elderly. Russell (2007) expressed that ageing is a gendered phenomenon that has special and different meanings for men and women but the differences in their experiences of ageing have been less well documented and their implications remain largely unexamined.

Past studies have raised some issues in this regard, for instance, Wood et al, (2005) found that females report symptoms more often than males and rely more on feelings of discomfort during physical activity in reporting health related quality of life (HRQL) as compared with males. In order to design interventions to enhance health-related quality of life among older adults, there is need to consider these potential sex differences. The situation of the elderly in Nigeria is very challenging considering the weak social support available (Adeokun, 1986). Studies have used different instruments to assess the health related quality of life of the elderly in Nigeria (Akinyemi et al, 2007; Akinpelu et al, 2006; Bayewu and Jegede, 1992, Gureje et al, 2008). Most of these studies did not take into cognizance the gender dimension in relating assessment of quality of life to other covariates. Few studies conducted in Europe that made attempt in relating gender issues to quality of life were conducted in hospitals and particularly among in-patients (Orfila, et al., 2006). To the best of our knowledge and through extensive literature search, there is no published article on household data relating to gender and quality of life, particularly among the elderly. This paper therefore attempts to bridge this gap in knowledge especially as related to the quality of life of elderly in South West Nigeria.

Theoretical orientations and empirical evidence

The concept of successful aging can be traced back to 1950s and was popularized in the 1980s. Successful aging has received a relatively significant attention from researchers in

the past few decades (Fentleman et al, 1990 & Rowe and Kahn, 1987). This is because early studies have exaggerated the onset of health disabilities in old age (Strawbridge et al, 2002 and Rowe and Kahn, 1987). Hence, Rowe and Kahn (1997) identified three components of successful aging which include low probability of disease or disability, high cognitive and physical function capacity and active engagement with life. Diane et al (2003) further extend the three components by identifying six different dimensions of successful aging. These are; no physical disability over the age of 75 as rated by a physician, good subjective health assessment, length of un-disabled life, good mental health, objective social support and self-rated satisfaction in eight domains namely marriage, income related work, children, friendship and social contacts, hobbies, community service activities religion and recreation/sports. Therefore for the purpose of this study, activity theory and feminists' gerontology theory shall be employed to explain the differences in the self assessments of quality of life between the aged males and females in South western Nigeria.

According to Havighurst and Albrecht (1953), activity theory explains the need for adults to remain active and involved in order to accomplish their goals and even to prolong their middle age. It believes that there is positive correlation between keeping active and aging well. It is a counterpoint to disengagement theory since it claims that a successful 'old-age' can only be achieved by maintaining roles and relationships. Therefore, successful aging goal accomplishment through maintaining activities is key even if the adult has limitations. Individuals who feel dependent on others may perceive that they are no longer useful and lose interest in continued living (Burbank 1992). The activities of daily living (ADL) considered in this study therefore becomes important in the assessment of the quality of life of the aged.

This theory however cannot explain the differences in the self assessment of the quality of life between aged males and females in relation to their assessment of daily living; hence the feminist gerontology theory will also be employed to capture this aspect. Feminist gerontology theory provides insights into understanding age and gender as key identity variables of analysis. According to Arber and Ginn (1991 and 1995), there are two important issues: first, power imbalances between males and females shape theoretical construction; second, a group's place within the social structure influences theoretical attention they are afforded. It follows that since older women tend to occupy a position of lower class status in terms of economic status than men of all ages and younger women, they are given less theoretical attention. The relations of distribution and production are influenced by gender across all societies and thus take on a gendered meaning. Age in women therefore has negative connotations as there is pressure on them to comply with male standards of desirability and the extent of male domination. It can therefore be argued that there is double standard of aging, arising from the sets of conventional expectations from age-pertinent attitudes and roles for each sex which apply in patriarchal society. Since patriarchal society exercises power through the chronologies of employment and reproduction, and through the sexualized promotion of a 'youthful' appearance in women, the awareness of a loss of a youthful appearance brings social devaluation of women and vulnerability to pressure is

penetrated by cosmeticisation (Arber and Ginn 1991). Older women therefore suffer from 'double jeopardy' thesis through age and sexual discrimination. This explains why the self assessment of quality of life between aged males and females may be significantly different especially in a patriarchal society among the Yoruba of South Western Nigeria.

Method

The current article utilized primary data that were collected in 2006 in south-western Nigerian[3] among elderly population (age range 60 to over 90 years), who spoke the Yoruba language and were ready to participate. The sample consisted of 947 elderly respondents (456 elderly men and 491 elderly women). The study was a cross-sectional survey covering three local government areas (LGAs) of Osun State in South-western Nigeria. A systematic sampling method was employed to select the respondents in the LGAs. Information was collected through the administration of questionnaires, using face-to-face interviews, on selected respondents. Two instruments (ADL and AMS) that have been widely tested and validated internationally were used to assess quality of life among elderly males and females. Information was also collected on spouse's information on quality of life.

Results

Background information

In this study, 947 respondents were interviewed with a sex ratio of 93 males to 100 females. Overall, about three out of every five of the respondents reside in urban areas. More than 50 percent across both sexes were aged 70 years and above with slightly more than one out of every five as an octogenarian. About 70 percent among males and almost 96 percent among females had no education or a maximum of primary school educational level. Also, the data showed that males were substantially more educated than females as almost 30 percent among males compared with only 3 percent among females completed secondary school or had a tertiary education.

Christianity is the main religion in the study area. The respondents were predominantly Christians (93%), with a handful of Muslims (5%) and very few Traditionalists (2%). Across marital status variable, considering the overall figure, about 47 percent were married, 12 percent unmarried (divorced, separated or never married), and 42 percent were widow/widowed. Controlling for sex, among males, 68 percent were currently married, 25 percent were widowed and 7 percent unmarried. The distribution among females showed that almost 3 out of every 5 were widowed, about one-quarter were married with husband currently alive while about 16 percent were unmarried. More than 3 out of every 5 respondents were in monogamous family type. About 42 percent of men compared with 54 percent of females were engaged in productive activities within the last 12 months. Trading and farming activities formed the

[3] It was collected primarily for a Ph.d dissertation for the lead author.

bulk of work reported with about 42 percent respondents. About 5 percent of male compared with less than 1 percent of female were into private employment, while less than 3 percent were into government employment. Government pensioners constituted less than 1 percent (0.9 % males vs. 0.4% females). In all, half of the respondents (51.5%) were not in any form of gainful employment.

Table 1 : Percentage distribution of respondents by socio-economic background across gender

Socio-economic variable	Male (N=456)	Female (N=491)	Total (N=947)
Residence			
Urban	57.0	64.4	60.8
Rural	43.0	35.6	39.2
Age			
60-65 years	24.3	28.9	26.7
66-70 years	23.0	20.0	21.4
71-75 years	16.7	9.2	12.8
76-80 years	15.1	18.3	16.8
81 years and above	20.8	23.6	22.3
Education			
Primary or less	70.6	96.5	84.1
Secondary school completed	9.0	1.8	5.3
Tertiary school	20.4	1.7	10.7
Religion			
Christian denominations	90.3	95.9	93.2
Islam	7.0	2.9	4.9
Traditional and others	2.7	1.2	1.9
Marital Status			
Unmarried	6.8	15.9	11.5
Married	68.2	26.5	46.6
Widow/widowed	25.0	57.6	41.9
Family type			
Monogamous	68.0	59.9	63.8
Polygamous	32.0	40.1	36.2
Current Work status			
Work within the last 12 months	42.0	54.4	48.5
No work within the last 12 months	58.0	45.6	51.5
Type of work within the last 12 months			
No work at all	58.0	45.6	51.5
Self-employed/Trading/Farming	32.9	51.5	42.6
Government employment	3.5	2.0	2.8
Private employment	4.6	0.4	2.4
Government pensioner	0.9	0.4	0.6

Activities of daily living

In this study, two indicators were used to investigate the self-health assessment of the elderly. The first is the Activities of Daily Living (ADL) instrument and the Aging Male Symptoms (AMS) scale. These two instruments have been conventionally found very reliable and valid in assessing the state of health of the elderly population. Activities of Daily Living (ADL) examine the activities which they needed to do as part of their daily lives. They were asked if they could do fourteen activities without any help, or with some help or they cannot do them at all. Respondents were asked about their self-assessment as well as the assessment of their spouse on the 14 items variables.

According to the distribution for the male respondents in Table 2, it is clear that their self assessment shows that their wives performed better than them in all the daily activities except in getting to the toilets on time. For instance, while 74.1% of the respondents can get to walking distance without any help, 82.8% of their spouses can do the same activity without any help. The results also follow similar pattern for activities such as dress and undress oneself (82% of male respondents against 85.7% of their spouses), take medication by self (78% of male respondents against 86.3% of their spouses) and bath oneself (77.9% of male respondents against 85.4% of their spouses).

It is important to note that the gap in self assessment is wider in activities that are traditionally female dominated among the Yorubas such as going for shopping (59.7% of male respondents as against 77.5% of their spouses), prepare your own meal (56.1% of male respondents as against 80.4% of their spouses and do your housework (66.7% of males as against 83.9% of their spouses). In a similar manner, the proportion of male respondents, who were not able to do many of the activities at all are also higher than that of their spouses. For instance, 19.5% of male respondents as against only 8.8% of their wives could not go for shopping, 19.5% of the respondents as against 9.4% of their wives could not take care of their appearance and 14.3% of the respondents as against 8.5% of their wives could not bath themselves at all. (See Table 2 for details). The distribution for female respondents shows a similar pattern; hence the female respondents' assessment of the daily activities revealed that they are better than their husbands in all the 14 activities considered in this study (Table 2).

Table 2: Percentage distribution of respondents by assessment of Activities of Daily Living (ADL) by gender

Activities of daily living	**Male**		**Female**		**Both**	
	Respondent (n=456)	Spouse[4] (n=342)	Respondent (n=491)	Spouse[5] (n=208)	Respondent (n=947)	Spouse[6] (n=550)
1. Get to places out of walking distance:						
Not able	9.0	9.4	16.3	19.7	12.8	13.3
Some help	16.9	7.9	9.4	10.6	13.0	8.9
No help	74.1	82.8	74.3	69.7	74.2	77.8

[4] Excluding Male Widower
[5] Excluding Female Widow
[6] Excluding widows

Activities of daily living	**Male**		**Female**		**Both**	
	Respondent (n=456)	Spouse[4] (n=342)	Respondent (n=491)	Spouse[5] (n=208)	Respondent (n=947)	Spouse[6] (n=550)
2. Go shopping/to the market:						
Not able	19.5	8.8	18.5	21.2	19.0	13.5
Some help	20.8	13.7	9.2	13.5	14.8	13.6
No help	59.7	77.5	72.3	65.4	66.2	72.9
3. Prepare your own meal:						
Not able	20.4	8.8	17.7	22.6	19.0	14.0
Some help	23.5	10.8	8.6	14.4	15.7	12.2
No help	56.1	80.4	73.7	63.0	65.3	73.8
4. Eat on your own:						
Not able	8.6	10.2	8.2	37.5	8.3	20.6
Some help	8.3	4.1	6.7	7.7	7.5	5.5
No help	83.1	85.7	85.1	54.8	84.2	74.0
5. Do your housework:						
Not able	16.7	8.2	15.9	26.9	16.3	15.3
Some help	16.7	7.9	11.0	19.7	13.7	12.4
No help	66.7	83.9	73.1	53.4	70.0	72.4
6. Take medications by self:						
Not able	13.2	9.4	10.4	29.3	11.7	16.9
Some help	8.8	4.4	6.9	12.5	7.8	7.5
No help	78.1	86.3	82.7	58.2	80.5	75.6
7. Handle your own money:						
Not able	9.0	10.8	7.1	38.9	8.0	21.5
Some help	7.7	4.1	7.7	7.7	7.7	5.5
No help	83.3	85.1	85.1	53.4	84.3	73.1
8. Make contact when needed:						
Not able	7.7	10.2	6.7	36.5	7.2	20.2
Some help	7.5	3.8	6.1	8.2	6.8	5.5
No help	84.9	86.0	87.2	55.3	86.1	74.4
9. Dress and undress yourself:						
Not able	7.9	10.8	7.3	35.1	7.6	20.0
Some help	10.1	3.5	7.7	11.1	8.9	5.5
No help	82.0	85.7	84.9	53.9	83.5	74.4
10. Take care of your own appearance:						
Not able	19.5	9.4	19.8	31.7	19.6	20.0
Some help	11.2	7.9	9.2	15.4	10.1	6.4
No help	69.3	82.8	71.1	52.9	70.2	73.6
11. Walk 2km:						
Not able	17.1	8.5	15.9	30.8	16.5	17.8
Some help	12.7	12.3	9.4	13.5	11.0	10.7
No help	70.2	79.2	74.8	55.8	72.5	71.5

Activities of daily living	Male		Female		Both	
	Respondent (n=456)	Spouse[4] (n=342)	Respondent (n=491)	Spouse[5] (n=208)	Respondent (n=947)	Spouse[6] (n=550)
12. Get in and out of bed:	16.0	8.2	11.8	28.4	13.8	16.9
Not able	5.9	6.1	6.9	15.4	6.4	12.7
Some help	78.1	85.7	81.3	56.3	79.7	70.4
No help						
13. Bath yourself						
Not able	14.3	8.5	10.6	32.2	12.4	15.8
Some help	7.9	6.1	6.9	11.1	7.4	9.6
No help	77.9	85.4	82.5	56.7	80.3	74.6
14. Get to the toilet on time :	16.3	19.7	19.8	30.8	9.0	17.5
Not able	9.4	10.6	9.2	13.5	16.9	8.0
Some help	74.3	69.7	71.1	55.8	74.1	74.6
No help						

Source: Author's fieldwork, 2006

Assessment of quality of life (AMS)

The Aging Male Symptoms instrument was also employed to assess self reported quality of life among the sampled elderly population. The instrument was based on a 17-variable scale to assess general well-being of the subjects. To each of the variable item, respondents were to rate their present situation as very low, low, moderate, high and very high. The distribution of the respondents according to the items is as presented in Table 3.

More women than men reported high (24% as against 22.2%) or moderate (35% as against 25%) general well being. Also, smaller proportion of women compare to men reported high level of sleeping problems (7.7% of women as against 11% of men), nervousness (18.7%women as against 20.0 of men), physical exhaustion (9.4% of women as against 16.2% of men), decrease in ability/frequency to perform sexually (7.7% of women and 18.4% men) and decrease in sexual desire/libido (11.6% women and 16.7% men) (Table 3). On the other hand, more women than men reported high level of problems such as muscular pain (31.6% women and 24.8% of men), excessive sweating (16.9 of women and 7.9% of men), anxiety (26.3% of women and 18.9% of men), decrease in muscular strength (25.1% of women and 18% of men) and depressive mood (27.7% of women and 24.3% of men). Higher proportion of men than women however have a very low feeling of increase need for sleeping (35.8% of men as against 29.9% of females), irritability (33.8% of men and 29.5% of women) and the feeling that one has passed his/her age (25.7% of men and 20.2% of women).

Generally, there is a decrease in sexual inclination among the elderly. Females reported low decline in sexual feelings. About 29 percent of males compared with 19 percent of females reported high decline in sexual performance. More than 25 percent of males compared with 16 percent of females reported high decrease in morning erection or sexual urge. The data showed that decline in sexual feelings is more pronounced

among males than females while females reported high decline in general activities than the males. Males also expressed the feelings of decline in productivity and the feelings that they have passed their peak than females.

Table 3: Percentage distribution of respondents by assessment of quality of life

Variable	Male (n=456)	Female (n=491)	Both (n=947)
Decline in your feeling of general well-being (general state of health, subjective feeling)			
Very low	21.7	17.7	19.6
Low	19.7	18.5	19.1
Moderate	25.0	35.0	30.2
High	22.2	24.0	23.1
Very high	11.4	4.7	7.9
Joint pain and muscular ache (lower back pain,joint pain, pain in a limb, general back ache):			
Very low	20.4	16.7	18.5
Low	25.2	22.2	23.7
Moderate	18.6	20.6	19.6
High	24.8	31.6	28.3
Very high	11.0	9.0	9.9
Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain):			
Very low	32.7	22.2	27.2
Low	24.6	41.6	33.4
Moderate	32.9	17.7	25.0
High	7.9	16.9	12.6
Very high	2.0	1.6	1.8
Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness):	35.8	29.9	32.7
Very low	20.2	29.5	25.0
Low	30.0	21.2	25.5
Moderate	11.0	7.7	9.3
High	3.1	11.6	7.5
Very high			
Increased need for sleep, often feeling tired			
Very low	32.9	26.7	29.7
Low	41.2	33.8	37.4
Moderate	15.1	21.8	18.6
High	8.8	6.5	7.6
Very high	2.0	11.2	6.8
Irritability (feeling aggressive, easily upset about little things, moody):	33.8	29.5	31.6
Very low	36.0	38.5	37.3
Low	25.0	17.5	21.1
Moderate	3.7	3.9	3.8
High	1.5	10.6	6.2
Very high			

Variable	Male	Female	Both
Nervousness (inner tension, restlessness, feeling fidgety):			
Very low	31.6	26.3	28.8
Low	29.6	39.7	34.9
Moderate	17.1	13.9	15.4
High	20.2	18.7	19.4
Very high	1.5	1.4	1.5
Anxiety (feeling panicky):			
Very low	30.5	23.2	26.7
Low	31.4	32.8	32.1
Moderate	13.2	15.1	14.2
High	18.9	26.3	22.7
Very high	6.1	2.7	4.3
Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities):	22.8	20.2	21.4
Very low	38.2	36.9	37.5
Low	19.5	23.6	21.7
Moderate	16.2	9.4	12.7
High	3.3	10.0	6.8
Very high			
Decrease in muscular strength (feeling of weakness):			
Very low	19.1	18.1	18.6
Low	36.0	32.0	33.9
Moderate	15.1	21.2	18.3
High	18.0	25.1	21.7
Very high	11.8	3.7	7.6
Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use):			
Very low	20.4	17.9	19.1
Low	30.7	28.9	29.8
Moderate	18.4	22.0	20.3
High	24.3	27.7	26.1
Very high	6.1	3.5	4.8
Feeling that you have passed your peak:			
Very low	25.7	20.2	22.8
Low	27.2	26.1	26.6
Moderate	20.2	28.1	24.3
High	21.9	14.9	18.3
Very high	5.0	10.8	8.0
Feeling burnt out, having hit rock-bottom:			
Very low	28.3	21.4	24.7
Low	31.6	35.4	33.6
Moderate	16.7	22.0	19.4
High	18.9	9.0	13.7
Very high	4.6	12.2	8.6

Variable	Male	Female	Both
Decrease in beard growth:			
Very low	29.8	26.3	28.0
Low	25.4	31.8	28.7
Moderate	19.1	21.0	20.1
High	19.3	13.4	16.3
Very high	6.4	7.5	7.0
Decrease in ability/frequency to perform sexually:			
Very low	33.3	44.8	39.3
Low	20.6	21.4	21.0
Moderate	17.3	14.7	16.0
High	18.4	7.7	12.9
Very high	10.3	11.4	10.9
Decrease in the number of morning erections/sexual urge			
(for male):	44.7	75.8	60.8
Very low	19.1	10.0	14.4
Low	10.1	4.9	7.4
Moderate	16.7	4.9	10.6
High	9.4	4.5	6.9
Very high			
Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse):			
Very low	43.6	52.1	48.1
Low	12.9	11.2	12.0
Moderate	16.9	20.6	18.8
High	16.7	11.6	14.0
Very high	9.9	4.5	7.1

Discussion

The aim of the article is to compare self-reported quality of life across gender and provide some plausible explanations for the variance. Evidence from the data showed that assessment of quality of life through ADL instrument feared better among females than males. This is against the earlier findings conducted in Bangladesh that older females were more likely to report that they had difficulty in performing activities of daily living (ADLs) in comparison to their age-matched male counterparts (Rahman and Liu, 2000). This is because most of the items in the ADL scale were issues considered as female dominated chores among the Yorubas. Activities such as shopping, washing, cleaning, cooking and other household chores are female dominated and most young males have difficulties performing them. It is therefore expected and not surprising that the elderly males have similar problem among the Yorubas. Hence, their reported poor performances may not necessarily be as a result of their ageing condition or may have been compounded by the fact that they are not used to it from their youths. This raised some issues about cultural factors in the assessment of quality of life.

A review of ageing situation in Sub-Saharan Africa provided some useful insight into the socio-cultural context in influencing individuals. The Yorubas are very rich in culture

and many of these cultural values have gender implications. For instance, a man is considered as *responsible* only when he is able to provide for his households basic needs. These needs varied and may be very burdensome. From provision of food and shelter to training of children in schools to meeting other social needs of the family were assumed as a man's responsibility. Women in most cases were considered as a secondary provider and in some cases, a financial liability to the husband. Even when a woman is economically viable and financially stable, the bulk of the house finances rest on the man. Although, existing literatures have placed very high emphasis on the male dominance in many traditional African societies, there is the need for the understanding of the influence of expected roles and responsibility on health status.

Also, there are many other cultural factors that may be important in this discourse. In many Yoruba communities, it is expected that men be older than their spouse(s). Also, the initiation of nuptial relations commenced with the understanding that *the man is ready.* He is expected to be aware of the responsibilities of marriage and will be expected to provide a base for this. Polygamous marriage is a common practice in Yorubaland. Men are culturally permitted to marry more than one wife. The consequences of these in meeting the demands of the wives and some of the attached responsibility may have some consequences on the man.

The AMS scale covered three major issues in quality of life which include; psychological (items 13, 11, 6, 8 and 7), somatic (items 2, 3,5, 1,4, 10 and 9) and sexual (items 15, 16,17, 12 and 14) factors. Across somatic measures such as general well being, joint pain and muscular ache, decrease in muscular strength and physical exhaustion among others, it is obvious that women are more likely to suffer from some of the items except for excessive sweating. This is in line with the earlier findings that females report symptoms more often than males and rely more on feelings of discomfort during physical activity in reporting health related quality of life (HRQL) as compared with males (Wood et al, 2005). Elderly males are more adversely affected in the sexual measures. O'Brien (2010) found that older adults remain interested and engage in sex, yet many experience bothersome sexual problems that can compromise both health and relationships. As noted sexuality is an important part of a healthy and engaged life at older ages for both women and men and there is a significant gender difference in senior sexuality. While aging is a partnered experience for most men, women's sexuality is more often affected by the death or poor health of their spouse. Hence, health is a more important indicator for many aspects of sexuality than is age alone. (O'Brien 2010). It is therefore consistent to conclude that it is imperative to consider gender differences in the assessment of health-related quality of life among older adults. There was however no major difference in psychological factors along gender line in this study.

The descriptive analysis employed though limited in understanding the factors associated with these self assessment, was able to provide some basic information on the variance of quality of life among elderly male and female. The study concluded that quality of life among the elderly is greatly affected by gender issues. Further analysis on the factors predicting the outcome will be appropriate to shed more light on this.

REFERENCES

Arber, S & Ginn, J. (1991) *Connecting Gender and Ageing*, Oxford, Oxford University Press.

Arber, S. & Ginn, J. (Eds.) *Connecting Gender and Ageing: a sociological approach*, Oxford, Oxford University Press

Adeokun, L. A. (1986). Aging and the status of the elderly in Nigeria. *Journal of Gerontology* 19(2), 82-6.

Akinyemi, A., Bamiwuye O., et al. (2008). The Nigerian Aging Males' Symptoms scale. Experience in elderly males. *Aging Male* 11(2), 89-93.

Akinpelu, A. O., Maruf F. A., et al. (2006). Validation of a Yoruba translation of the World Health Organization's quality of life scale--short form among stroke survivors in Southwest Nigeria. *African Journal of Medical Sciences* 35(4), 417-24.

Baiyewu, O. & Jegede R. O. (1992). Life satisfaction in elderly Nigerians: reliability and factor composition of the life satisfaction Index Z. *Age and Ageing* 21(4), 256-61.

Burbank, P. M. (1992). An exploratory study: Assessing meaning of life among older adult clients. *Journal of Gerontological Nursing*, 18(9), 19–28.[PubMed link]

Gilmer, D. F. & Aldwin, C. M. (2003). *Health, illness, and optimal ageing: biological and psychosocial perspectives*. Thousand Oaks, Sage Publications.

Fentleman, D. L., Smith, J & Peterson, J (1990), *Successful ageing in a postretirement society*; in Baltes, M. & Baltes, P. (1990). *Successful ageing: perspectives from the behavioral sciences*. Cambridge, UK: Cambridge University Press.

Gureje, O., Kola L., et al. (2008). Determinants of quality of life of elderly Nigerians: results from the Ibadan study of ageing. *African Journal of Medical Sciences* 37(3), 239-47.

Havighurst R.J, & Albrecht R.E (1953). Older People. Longman, London.

O'Brien S (2010) Sex and Aging: Survey Finds Sexual Desire and Activity Important to Seniors. [Online] Available from: http://seniorliving.about.com/od/healthyseniorsex/a/senior_sex_surv.htm [Accessed on 19th March 2010].

Orfila F., Ferrer M., Lamarca R., Tebe C., Domingo-Salvany A., & Alonso J. (2006). Gender differences in health-related quality of life among the elderly: the role of objective functional capacity and chronic conditions. *Social Science and Medicine* 63(9), 2367-80 [Accessed on Epub on August 1, 2006].

Rowe J.W & Kahn R.L (1987) Human Ageing: Usual and successful. *Science* 237 (4811), 143-149. Doi:10.1126/science.3299702. [PMID 3299702]

Rowe J.W & Kahn R.L (1997) Successful ageing. *Gerontologist* 37 (4), 433 -40. PMID 9279031.

Russell C. (2007) What Do Older Women and Men Want? Gender Differences in the 'Lived Experience' of Ageing. *Current Sociology*, 55(2), 173-192.

Strawbridge W.J., Wallhagen M.I., Cohen R.D. (2002). Successful ageing and well-being: self-rated compared with Rowe and Kahn. *Gerontologist* 42 (6), 727–33. [PMID 12451153]

Wood R. H., Gardner R. E., Ferachi K. A., King C., Ermolao A., Cherry K. E., Cress M. E., and Jazwinski S. M. (2005) Physical function and quality of life in older adults: sex differences. *Southern Medical Journal* 98(5), 504-512.

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