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# Adjusting to changes in the intergenerational care systems: Care for the elderly in Nigeria

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Master in Sociology

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This work is dedicated to the memory of my grandmother, Alhaja Alatu Aduke Ajibola (Nee Dindi), a champion of the inter-generational care system.

**Resumo**

Cuidar uns dos outros desde o nascimento até à morte faz parte dos esforços humanos. Os pais cuidam dos filhos com a expectativa de que os filhos retribuam quando os pais ficarem velhos e frágeis. Este arranjo de cuidados intergeracionais é possibilitado pela cohabitação multigeracional. A transição deste regime de co-habitação para um regime de vida familiar nuclear continua a criar um vazio de cuidados para os idosos. À luz desta transformação, é necessário um arranjo para garantir que as necessidades de cuidados dos idosos sejam atendidas. Tal como acontece no Ocidente, os idosos nigerianos abraçariam a ideia de lares para idosos se não obtivessem os cuidados necessários dos cuidadores familiares? Esta é a pergunta subjacente que este estudo tenta responder. O estudo fornece um exame aprofundado de como os idosos nigerianos percebem e navegam pelas mudanças nos sistemas de cuidados intergeracionais. Os resultados deste inquérito transversal abrem caminhos para uma investigação mais aprofundada. Uma abordagem longitudinal pode fornecer informações adicionais sobre como a perceção muda ao longo do tempo.

Palavras-chave: Idosos, co-habitação multigeracional, cuidados intergeracionais, reciprocidade, lares de idosos.

## Abstract

Caring for one another from birth to death is part of human endeavours. Parents take care of their children with the expectation that the children will reciprocate when the parents become old and frail. This inter-generational care arrangement is made possible by multigenerational co-dwelling. The transition from this co-dwelling arrangement to nuclear family living arrangements continues to create a care vacuum for the elderly. In light of this transformation, there is a need for an arrangement to ensure the care needs of the elderly are met. As it is in the West, would Nigerian elderly embrace the idea of care homes for the elderly if they do not get the necessary care from family caregivers? This is the underlying question this study attempts to answer. The study provides an in-depth examination of how elderly Nigerians perceive and navigate changes in intergenerational care systems. The findings from this cross-sectional survey open avenues for further investigation. A longitudinal approach might provide additional insights into how the perception changes over time.



**Keywords:** Elderly, multigenerational co-dwelling, intergenerational care, reciprocity, care homes.

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# CHAPTER ONE

## INTRODUCTION

All over the world, caring for one another from birth to death is part of human endeavours, especially caring for the vulnerable in society, such as children, pregnant women, the physically and mentally challenged, and the elderly. It is encouraged among the people, and governments can support the care for these vulnerable groups via policy interventions. This work focuses on the elderly, and the title is: Adjusting to Changes in the Intergenerational Care System: Care for the Elderly in Nigeria. Traditionally, Intergenerational care is a form of care where caring for one another is based on reciprocity. Parents take care of their children with the expectation that the children will reciprocate when the parents become old and frail (Tanyi et al., 2018; Dwyer et al., 1994), a form of social care bank. In Western countries, some institutions manage care homes specifically designed for their care, as there are for the sick and injured being treated in hospitals.

In Africa, though caring for the sick or injured outside of the home is practiced across cultures, the idea of living in care homes for the aged is strange and may be difficult for Africans to encourage or adopt. Rather, the elderly are cared for within the household and depend on an intergenerational care system that transcends the parent-child relationship and includes a care system structured to reciprocate among members of the extended family structure (Tsai & Dzorgbo, 2012).

Walker et al. (1995, p. 403), in their work "*Informal Caregiving to Aging Family Members: A Critical Review,*" offer a criterion for the definition of caregiving based on "dependence on another person for any activity essential for daily living…" They define caregiving as "…providing assistance above and beyond the aid given to physically and psychologically healthy members and includes assistance provided to someone dependent on that assistance." The assistance may entail physical, emotional, and financial support to manage the realities associated with aging (Keister et al., 2018; Cleland et al., 2021: 766). Nigerian realities of unemployment, low salaries, meager pensions, and lack of social support (Okumagba, 2011; Tanyi et al., 2018) indicate that the elderly in Nigeria need care and support.

## 1.1 Nigerian Conceptual and Contextual Peculiarities: The Elderly and Their Care

In Nigeria, care for the elderly occurs within the household, and it is the responsibility of the younger generations as a reward for caring for them prior in life. This care sums up caregiving and aiding, for instance, among the Yoruba of Southwest Nigeria, services or support rendered to assist the elderly, either monetary or non-monetary, is ***itoju*** (care), so far it helps the elderly ease the difficulty of aging. It is an obligation for children to care for their parents, whether elderly or not. Also, it is immaterial whether the elderly can offer a service or commodity in return, or not (Tsai & Dzorgbo, 2012), and the inability of children to fulfill this responsibility carries a social stigma. Thus, the children are beholden to care for their parents. This 'indebted reciprocity' may be considered a variant of generalized reciprocity. Here lies the significance of understanding what it means to care for the elderly in Nigeria.

Of Nigeria's 227,800,000 total population, 3%, representing 6,834,000 people aged 65 years and above (PRB, 2024). However, there is no adequate demographic data or certainty about who lives where and at what time in the country. Having mentioned this, there is a need for ways to assess and address their care needs where necessary. Especially, as increasing urbanization and the search for economic opportunities in the cities continue to transform the household setup from a multi-generational household dwelling into a nuclear family living arrangement. Observations show that, without multi-generational household dwellings, the intergenerational reciprocal care system, which had been a reliable source of care for the elderly, will continue to collapse. In light of this transformation and its attendant consequences for elderly care, would the elderly opt to live in care homes to avoid the difficulties caused by the transformation in the family-based caregiving system? This is the underlying question on which this research is built.

## 1.2 Research questions

The general research question is how Nigerian society can sustainably provide equitable, affordable, culturally sensitive, and person-centered care for its elderly population in the face of its demographic realities, economic uncertainties, and evolving social structures, according to the perceptions, preferences, and experiences of its elderly population. Other, more specific research questions are as follows:

1. What are the elderly's perceptions of the reciprocal care received in old age?

2. Which care preferences do the elderly value more, between economic or non-economic forms of support?
3. How would the elderly prefer to adjust to the shift in the intergenerational care system?
4. Would the elderly opt for care homes to avoid the burdens caused by the transformation in the family-based caregiving system?

## 1.3 Research Objectives

The general objective is to ascertain how elderly care in Nigeria can be improved among the aged population according to their perceptions, preferences, and experiences. Other more specific objectives include:

1. To understand how the elderly feel about their state of care.
2. To ascertain if the elderly perceive a shift in reciprocal care received from their children.
3. To ascertain what they can tolerate between economic and non-economic deprivation.
4. To assess their views on how they wish to adjust to the disruptions in the inter-generational care system
5. To ascertain if the elderly would live in an elderly home if provided for them.
6. To assess the role of the respondents' belief system in their view of care homes for the elderly.

## 1.4 Methods

The study aimed to address the questions and achieve the aforementioned objectives by collecting primary data in Epe Local Government Area (LGA), one of the twenty LGAs in Lagos State. It has a population size of 572,927, about 2.2% of Lagos State's 26,435,406 estimated population (LBS, 2020). This work relied on data from the Lagos State Bureau of Statistics (LBS, 2020), in combination with the statistics from the Population Reference Bureau (PRB, 2024), to calculate an operational sample size for the study. Thus, at a 7% margin of error, the sample size for this study was 194, which was rounded up to 200 respondents.

The study used a survey design to collect and analyse data from respondents aged 65 to 89 years old, using questionnaires designed in Google Forms, which were administered via face-to-face interaction. The study adopted convenience and snowball sampling techniques. The first stage of sampling utilized convenience sampling to select ten wards out of the nineteen in the LGA. The

second sampling entailed the selection of respondents. At this stage, convenience and snowball sampling techniques were deployed to select the respondents. This study aims to contribute to the knowledge of the nature of care, expectations, and options that the elderly population in the Epe Local Government Area of Lagos State, Nigeria, were willing to access.

## 1.5 Dissertation Outline

This work comprises five chapters: Introduction, Theoretical Framework and Literature Review, Methodology, Data Analysis and Presentation, and Conclusion. The first chapter is the introductory part, which lays out the reason and goals of the study. The second chapter discusses two interesting theories of reciprocity by Marcel Mauss and Alvin Gouldner, as well as reviews of relevant literature. Chapter three is the methodology, which outlines the strategy for the fieldwork in order to achieve the objectives of the research. Chapter four deals with the presentation, analysis, and interpretation of the data. Chapter five discusses a concise conclusion of the findings.

# CHAPTER TWO

# THEORETICAL FRAMEWORK AND LITERATURE REVIEW

## 2.1 Theory of Gift by Marcel Mauss and Theory of Reciprocity by Alvin Gouldner

In his book, The Gift, published in 1950, Marcel Mauss examines the concept of gift as a representation of reciprocity. He defines it as a type of exchange and explains how it serves as a basis for interaction within traditional societies.

The theory of the gift emphasizes human solidarity, regarding obligations associated with the gift, the obligation to give, to receive, and to reciprocate what was given. Mauss (2002) uses the North American Potlatch as an illustration of a comprehensive giving system, a reciprocity framework where the status of both the giver and receiver is at stake. The system's rule dictates that every gift must be reciprocated in a certain manner, creating a continuous cycle of exchanges across generations. In some instances, the return is of equal value, establishing a stable hierarchy of statuses; in others, the return must surpass the original gift's value, leading to a competitive escalation for honour (see pp. xi-xii). This point supports the sense of obligation that children in Nigeria have towards caring for their elderly.

Gouldner's (1960 in Lodewijkx, 2008) norm of reciprocity posits that exchange is regarded as a norm of returning favours. He argues that this norm is universal; nearly all societies support some type of reciprocity norm, with only a few individuals excluded from it (the very young, the sick, and the elderly). The norm specifies not just returning favours, but also discourages harming those who have assisted someone before; failure, which attracts penalties. Some of the penalties may be in the form of a rebuke against the person who breaks the chain of reciprocity. The rebuke may usually be tied to the spiritual essence of reciprocity, carrying negative repercussions. Therefore, people are compelled, by the vitality of karma, to return favour in good measure (Lodewijkx, 2008).

Within the framework of this research on intergenerational care, these two theories of reciprocity are particularly significant. Parents contribute to their children during their early years and subsequently anticipate care and assistance in their old age in return. In numerous Nigerian communities, adult children often feel beholden to their parents and view caregiving as a moral obligation and a societal expectation (Eke, 2024). This obligation is frequently reinforced by

religious tenets (Eke et al. 2024; Eboiyehi, 2019), societal pressures (source Barbalet, 2025), and cultural narratives (Tanyi et al., 2018; Pan & Bian, 2025; Qi, 2025; Yan, 2025), which emphasize the duty to care for elders.

## 2.2 Concept of Intergenerational Care

The word care means different things. Generally, care needs in care homes revolve around either Assisted Daily Living (ADL) needs, where help is offered to those unable to manage their physical functioning and personal hygiene, or Instrumental Assisted Daily Living (IADL) needs, where the need involves more complex activities necessary for daily living, such as shopping, cooking, housekeeping, etc. But care is more than that, especially in Africa, where care falls within the obligations and responsibilities of family members. For instance, parents raise their children by providing food, shelter, and socialization. Younger individuals help the elderly, while healthy individuals support those who are sick. As such, care extends beyond the complementary quality of ADL and IADL in which one individual meets the needs of another. Care has emotional implications, reflecting feelings of concern, commitment, and attachment to another person (Barbalet, 2025). Therefore, to offer family care in Nigeria is not just a responsibility but also an obligation. This signifies that it involves affective dedication. Perhaps, this is the difference between institutional caregivers and family caregivers, one that the family caregivers and receivers understand.

The insightful capacities of human actors suggest that the elderly are self-aware of the societal expectations placed on their children and understand the situation and conditions that shape the actualization of these obligations. Thus, through their agency, they may act differently to adopt or reject a new idea or product. When the product or service is unavoidable, individuals consider different options and may decide how to interact with the new phenomenon. Their choices can be influenced by the conditions imposed by social structures such as social status, norms, economic situation, belief system, and access. For instance, not everyone can afford or accept care homes. These two factors, i.e., obligation and agency, can shape the motivation, feasibility, and sustenance of care homes for the elderly if fully introduced in Nigerian society.

Intergenerational care refers to a reciprocal caregiving model where generations provide support to one another, often within familial structures (Tanyi et al., 2018; Pan & Bian, 2025). This model is deeply rooted in cultural practices, particularly among the Yoruba, Igbo, Tiv, Fulani, Ibibio, Edo, and Hausa ethnic groups in Nigeria. The Yoruba concept of "itoju" embodies this practice, signifying care or support for the elderly as an obligation. Similarly, among the Igbo, the tradition of "omugwo" involves postpartum care provided by the maternal grandmother, highlighting the role of older generations in caregiving (Ezulike et al., 2024). The Hausa and Fulani community also exhibits strong filial piety, with extended families usually living together, ensuring mutual support (Gureje et al., 2008). In Nigeria, these intergenerational care systems are integral to the social fabric, ensuring that the elderly are cared for within the family unit. However, with increasing urbanization and migration, traditional family structures are changing, impacting the sustainability of family caregiving models (Qi, 2025; Pan & Bian, 2025). The shift from multi-generational households to nuclear families in urban areas creates challenges to continuing intergenerational care, necessitating a reassessment of caregiving practices to reflect the changing socio-economic dynamics.

## 2.3 Literature Review

Modernization is exemplified by improved health facilities, longer life expectancy, urbanization, and migration, leading to rapid changes from traditional to modern ways of doing things. In its wake, there is a weakening of the concept of reciprocity on the one hand and an increasing demand for human needs on the other (Eboiyehi, 2019). The need for care homes arose as a response to the changes brought about by modernization, rather than neglecting the elderly, by providing sustainable mechanisms to care for and support them. Meanwhile, the Nigerian elderly might interpret care homes as abandonment homes or a short-change of their earlier efforts.

### *2.3.1 Respect and Reciprocity: Care for the Elderly People*

Ghana and Nigeria share some similarities. A study of one may give you insights into the other. As such, I begin with the existing knowledge about intergenerational care in Ghana, where a survey focused on post-retirement lifestyles and care options available to the elderly. The research

examined the status of elderly individuals' lifestyles and care methods that are rapidly changing, especially regarding their post-retirement living arrangements within rural Ghana. This study was conducted in Nigeria, specifically in Epe Local Government Area, in Lagos State. Epe LGA has urban, suburban, and rural areas, which offer an opportunity for comparison to the study in rural Ghana. It is a place where its indigenes and others retire to live after years of sojourn in other bustling metropolitan parts of the state due to its low cost of living and quiet serenity.

Ofori (2022) conducted qualitative research in rural Ghana, using focus group discussions and interviews with the elderly and family caregivers. He finds that two types of elderly care, namely, reciprocated intergenerational care by family members and the elderly's self-care, are necessary to retain their dignity. The findings of this research within the Ghanaian context are comparable to those in Nigeria regarding perceptions of elderly care. As illustrated in the study, Ghanaians regard reciprocity as a key norm in the relationships between the elderly and their family caregivers, always associating the quality of care with previous contributions made by the elderly in their children. The study reveals that some elderly enjoy comfort, family support, and abundance in old age. Others face loneliness, poverty, and hunger (Ofori, 2022; Van der Geest, 2002). These contrasting realities shape family caregiving practices in Ghana.

Similarly, in Nigeria, the concept of reciprocity is robust, with adult individuals feeling a duty towards their parents, which shapes their support interactions (Akinrolie et al., 2020). The idea is especially significant in Nigeria, where family members are aware that the elderly need more than just monetary help; they also need emotional support, which can help them navigate the challenges of ageing. Imoh's (2022) work addresses the changing nature of family structures and societal transformations that might affect caregiving in urban areas. He advised that research should be conducted on how modernity affects conventional methods of caregiving.

In conclusion, the highlighted works suggest the importance of emotional ties in caregiving and that they compensate for the lack of monetary help, a concept that is relevant in both Ghanaian and Nigerian contexts.

### *2.3.2 Care and Support for the Elderly in Nigeria*

In Nigeria, there is a belief that caring for elderly individuals is a cultural right, as the elderly are viewed as representatives of ancestors, bearers of cultural customs, and intermediaries between

the physical realm and spiritual world (Eboiyehi, 2019). This perspective has influenced care expectations of the elderly, giving them a sense of entitlement to certain needs. Aside from that, generally, human beings have several needs that require fulfillment, including health, financial support, domestic assistance, and social engagement (James, 2024). The elderly may struggle with self-care, mobility, and interaction with their surroundings, thus requiring assistance to address these needs (Adamek et al., 2022). This section focuses on how elderly individuals cope with the lack of these necessities, given the decline in traditional care systems and their endurance of economic and emotional hardship.

In a couple of decades, Nigeria is poised to witness an increase in its elderly population, and the country may not be able to cope well with the care of its elderly, which has historically relied on family caregivers, as it continues to modernize, leading to a breakdown in the traditional structure and system. The lack of social support for the elderly, managing their health issues amidst a fading inter-generational care system, will become a challenge in Nigeria (Togonu-Bickersteth & Akinyemi, 2014). Ageing not only makes the majority of elderly individuals vulnerable to health issues but also to social and economic challenges (Gureje et al., 2008).

In Nigeria, the system of intergenerational care involves a web of care transfers between two or more generations of kin relations, necessitated by a sense of reciprocity, familial responsibility, and duty based on assistance previously provided by the family member concerned. Existing literatures have identified various challenges and factors contributing to the decline in care and support for the elderly, including high unemployment rates, insufficient resources (Imoh, 2022; Qi, 2025), the shift toward nuclear family structures (Yan, 2025), the migration of younger relatives and alterations in living arrangements and household types (Pan & Bian, 2025), modernization, economic constraints, marital status, and more (Gureje et al., 2008).

Studies such as that of Ezulike et al. (2024) and Mbah (2016) posit the importance of child's educational attainment and types of employment as determinants of whether their elderly receive care or otherwise. They missed two of the most important factors: earnings and emotional connection. Educational attainment and types of employment do not always confer high earnings, nor do they confer emotional connection, nor assure someone will take care of their elderly. Therefore, regarding the level of education in this study, we are interested in observing the impact

of education on the elderly's perception of care received and their thoughts about care homes for the elderly.

Feasibly, the resources available to individuals within the intergenerational care system can determine the quality of care given, received, and reciprocated. Insufficient resources from a family caregiver within this system can create a deficiency or imbalance (Togonu-Bickersteth & Akinyemi, 2014), which can impact the relationship. If resource limitations become severe, coupled with a favorable shift in norms, reality, and levels of need, there is a chance that the elderly and society may start to accept the need for care homes without excessive concern. Another factor affecting elderly care is the shift in living arrangements and means of production, which have limited the psychosocial support available to the elderly, leading to a significant generational divide in the kinship system (Mbah, 2016).

The elderly have adapted to the changing intergenerational care system and the lack of government policies in supporting them. The lack of government support for elderly care may have arisen because everyone knows families remain the primary source of assistance and care for the elderly.

Thus, the elderly have developed strategies to ensure a supported old age. Examples include relying on savings and investments in preparation for old age (Wahab & Isiugo-Abanihe, 2008). Also, having more children has historically been a resource for old age, considered as savings and investment. Women, in particular, have benefited from an unwritten arrangement where they care for their grandchildren as nursing mothers, traveling from one city to another and leaving men behind to deal with the empty nest. In the past, men sought care in old age by marrying a young wife as they approached old age or near retirement to avoid an empty nest. Usually, the children from these marriages would become the responsibility of their older siblings.

In traditional African societies, it was common for men to have multiple wives, especially younger ones, ensuring that there was usually someone at home even if others relocated to care for their grandchildren as nursing mothers. This was another strategy for men to avoid an empty nest. Children who moved to urban centers often sent funds to support their elderly parents in rural areas. Nowadays, this is changing. Today, families find it more difficult to care for their elderly members. As part of their strategies for old age, financially secure older adults tend to seek independence and are likely to pursue entrepreneurship even in their later years. Idehen (2021) asserts that these types of engagement can reduce issues such as social isolation and loneliness.

The ageing experience in Nigeria is shaped by many factors, including but not limited to socioeconomic conditions, access to healthcare, religious teachings, and cultural perceptions of ageing. Historically, the elderly in Nigeria have depended significantly on their families for support; however, contemporary societal shifts have disrupted these traditional support systems. This change highlights the need, as illustrated by Artner (2018), for the development of formal social support services to address the void left by the decline of informal care networks (Artner, 2018). Social support includes connections that offer material help, emotional comfort, and a feeling of belonging, fostering a sense of community for individuals (Behrendt et al., 2023).

The characteristics of social support networks and their role can affect outcomes (Ashida & Heaney, 2008; Cornwell & Laumann, 2015). Additionally, social support services offer essential financial and practical aid to elderly individuals who may face challenges related to limited resources and mobility. It provides them with a sense of belonging and lessens the stigma associated with ageing, as it creates opportunities for social engagement. It helps to alleviate the feelings of isolation and marginalization that many older adults encounter (Duku et al., 2015). Despite the many advantages of social support services for the elderly, non-existent or insufficient government support for the elderly and economic downturns have negatively impacted the livelihoods of family caregivers in Nigeria. Nevertheless, many family caregivers continue to embrace this role due to their inherent motivations to offer support to the elderly (Chukwu et al., 2022).

### *2.3.3 Care Homes for the Nigerian Elderly*

Care homes are institutionalized residences or facilities designed for the elderly. The idea behind these care homes is rooted in Western practices of caring for the elderly to attend to their needs, while family members pursue economic and social opportunities. Elderly individuals who are incapacitated, financially disadvantaged, isolated, and in need of companionship often find themselves in these facilities. Essentially, this idea contradicts the African principle of familial integration and collectivism, and it is challenging for certain cultural or religious groups who view it as a sign of irresponsibility by children or family members who place their elders in care homes (Oluwagbemiga & Tiwalade, 2017; Eke et al., 2024). Likely, the majority of the elderly people are also unwilling to use the few available in the country.

The care home service encompasses healthcare, social welfare initiatives, and community center activities to keep the elderly engaged and socially active. Access to and quality of these services vary significantly across different regions (Tanyi et al., 2018; Artner, 2018).

The study by Eke et al. (2024) explored the willingness of elderly individuals in Nigeria to utilize social support services. The work focuses on understanding the cultural and religious influences on the elderly's willingness to engage with such services for elderly care in Nigeria. He pointed out that cultural and religious beliefs impact the readiness of the elderly to seek social support services. This is not a surprise, as Tanyi et al. (2018) found that in many Nigerian communities, there exists a strong cultural expectation that family members, particularly children, are responsible for caring for their elderly relatives. This cultural norm can result in hesitance among the elderly to pursue external support, as it may be seen as a failure in familial duty or a sign of insufficient family care.

Additionally, religious beliefs can shape perceptions of social support services. For example, some religious teachings stress the importance of family and community involvement in caregiving, which may discourage the use of formal social support services (Wahab & Isiugo-Abanihe, 2008).

A better grasp of the influence of cultural and religious frameworks is essential for establishing care home services for the elderly in Nigeria. Such services must be religio-culturally sensitive and socially acceptable. Although some religious groups and affluent individuals have contributed to the establishment of care homes for the elderly in Nigeria, usage has been hindered by cultural norms because care homes for older people are culturally unacceptable. This type of care suffers from the stigma of destitution, resulting in limited public acceptance. The available care homes experience low occupancy rates, despite having good infrastructure and recreational amenities. Lack of usage has prompted the need to rent some of the rooms to non-elderly individuals to cover costs. Various factors such as cost, trust issues, cultural beliefs, and religious convictions have been cited as reasons for the low patronage (Akanji et al., 2002; Eke et al., 2024). While Eke et al. (2024) focus on the elderly's willingness to utilize care homes gleaned from cultural and religious beliefs, this work takes it further to unravel the agency at play in the elderly's decision-making process.

# CHAPTER THREE

# METHODOLOGY

A research design serves as a guide for researchers to achieve results that are consistent, replicable, and verifiable. It is carried out to describe, understand, explain, and predict a phenomenon. This research relies on a cross-sectional survey method, which requires direct contact between the researcher or field assistants to collect data at a particular point in time from a selected sample of respondents to describe or explain characteristics of the larger population at a particular point in time.

## 3.1 Research Population/Location of the Study

The research population for the study consisted of the total number of elderly individuals in Epe Local Government Area, Lagos, which was 14,622. The study included only the elderly who reside within the selected areas in Epe LGA, excluding visitors and those who engaged in economic activities but did not reside in these areas.

This study targeted elderly individuals (aged 65 - 89) living in Epe LGA, Nigeria. This population was suitable because the research aimed to investigate perceptions among the elderly who have needs for care and support as they cope with challenges associated with ageing. Focusing on this group enabled the researcher to explore the elderly's perceptions about care homes for the elderly as modernization continues to affect family caregiving (Pan & Bian, 2025; Yan, 2025). The population was accessible, and all participants were recruited through voluntary participation and informed consent.

This choice of Epe as the study area was because the LGA is one of the few LGAs in Lagos State where its indigenes and others retire to reside after years of sojourn in other bustling metropolitan parts of the state due to its low cost of living and quiet serenity. Epe Local Government is located in the southeastern part of Lagos State. It has a landmass of 641 sq Km, a water area of 324 sq km, totaling 965 sq km. Its demography comprises 47% males and 53% females, respectively (LBS, 2020). The residents are from different ethnic groups in Nigeria; it is predominantly inhabited by the Yoruba, as expected. The social status of the residents ranges from low to high. The LGA comprises urban, suburban, and rural areas. The local government was preferred due to these facts.

### 3.2 Sampling Frame

A sampling frame is the complete list of all units from which the sample is drawn. It was not possible to get an accurate sampling frame for this study due to a lack of data in the Local Government Area. It is a national problem. Epe Local Government (LGA) has a total population of 487,405 (LBS, 2020); 3% of this population is elderly, aged 65 years and above (PRB, 2024). The sampling frame for this study was 3% of 487,405, which is fourteen thousand six hundred and twenty-two (14,622) people.

### 3.3 Sample Size and Sampling Technique

The calculated sample size was 194, which was rounded up to 200 due to the peculiarity of the study area, comprising the elderly residents in the LGA with an upper age limit of 89. The researcher arrived at the sample size at a 95% confidence level with a 7% margin of error from a sampling frame of 14,622. The criterion for inclusion in the study considered 89 years as the upper age limit for the elderly, bearing in mind linguistic autonomy and agency, and it did not include elderly people with cognitive and/or mental difficulties.

The study adopted mixed sampling techniques to achieve some form of representativeness in the sample. The first sampling attempted a random sampling technique to select wards from two constituencies that made up the LGA in a ballot system. This was later modified after engagement with the resource persons in the area, who identified that some of the selected wards are cut off by water, requiring water transportation, which was considered too risky for the field assistants employed to assist in carrying out the field study. Therefore, some wards were retained from the random sampling, while the rest were selected based on convenience and safety to life. The second sampling involved the selection of final respondents. At this stage, convenience and snowball sampling techniques were deployed to select the respondents because there is no register from which the elderly can be selected, nor is there a reliable street list to choose from. Bryman (2012, pp. 201 - 202) explains that convenience sampling is one that is available to the researcher by its accessibility, while snowball sampling requires the researcher to make initial contact with a small group of people relevant to the research topic and then uses these to establish contacts with others. The study ensured social diversity in its selection of respondents, such as age, gender, ethnicity, status, and qualification.

Epe Local Government Area, like all LGAs in Nigeria, is divided into two constituencies, I and II. In Epe LGA, there are 8 wards in Constituency I and 11 wards in Constituency II, totaling 19 wards altogether.

**Constituency I:** Ajaganabe, Etita/Ebode, Ise/Igbogun, Lagbade, Oke Balogun, Popo Oba, Oriba/Ladaba, and Abomiti.

**Constituency II:** Agbowa, Agbowa Ikosi, Ago-Owu, Ejirin, Ibonwon, Ilara, Itoikin, Odomola, Odoragunsin, Orugbo, and Poka.

The following 10 were selected from the available 19 wards in the LGA based on the considerations mentioned earlier.

**Table 3.1 List of Selected Wards**

| Constituency | Selected 5 wards per Constituency |
|---|---|
| I | Ajaganabe, Etita/Ebode, Lagbade, Oke Balogun, and Popo Oba. |
| II | Ibonwon, Ilara, Odomola, Odoragunsin, and Poka. |

## 3.4 Research Instrument

The study utilised a questionnaire as a research instrument. The Google Forms' e-questionnaire deployed mainly closed-ended questions, which confined respondents to a number of predetermined responses by the researcher, and one open-ended question for age. The questionnaire was divided into sections namely the introduction, which talks about reason for the study and seek voluntary participation of respondents, the body which includes sections on socio-demographic data, perception of reciprocal care received, forms of care i.e., economic or non-economic (care preferences), preferred mode of adjustment to changes in intergenerational care, alternative opportunity for care, the elderly decision making, and the concluding part which asked for general comment and gratitude to the participants (see questionnaire in the appendix).

## 3.5 Administration of the Research Instrument

A structured Google Forms e-questionnaire was administered to the elderly in the selected areas in face-to-face interviews with the help of field assistants for a duration of 3 days. The field assistants were contracted because of the researcher's inability to travel back to Nigeria,

considering the cost of air travel. The field assistants were teachers from public secondary schools in the LGA. They were engaged because they have experience in field data collection. Fair remuneration and dignity of labour were ensured in utilising their services. They were offered training, including question-and-answer sessions to clarify any areas in the instrument that needed clarification. Each field assistant was required to administer 10 – 15 questionnaires per day for 3 days. Each field assistant earned more than 50% of the minimum monthly salary in Nigeria for the exercise, plus an additional provision of a mobile data bundle and N1,500 per day for their convenience. The questionnaire administration was closely and continuously monitored by me online, and two experienced field study supervisors moved around to ensure support and compliance with the goals of the field survey. They were equally compensated for the work.

### 3.6 Data Analysis

The responses obtained through the questionnaires constituted the primary data that were analysed in the study. Statistical tools such as frequency and percentage were used to perform univariate and cross-tabulation analyses.

### 3.7 Challenges

The study encountered some challenges; a few of them are worth mentioning.

1. The request for an official map and list of wards in the Epe LGA was not granted by the local government officials for 2 months. This created a setback for the study. Luckily, the previously unavailable list of wards in the country became accessible online because the Nigerian Independent National Electoral Commission (INEC) embarked on a nationwide voter registration exercise.
2. Administration and live monitoring of the questionnaires was very demanding, as Google Forms being submitted spontaneously had to be checked one by one. A few incongruencies were detected, which were corrected together with the field assistants.
3. The field assistants reported that mid-way in the administration of the questionnaires, some of the respondents wanted to know the benefit they would get for participating in the study; they were reminded that it was for academic purposes. The respondents largely cooperated with the field assistants because they are known in the communities.

# CHAPTER FOUR

# DATA ANALYSIS, INTERPRETATION, AND DISCUSSION OF FINDINGS

## 4.1 Introduction

This chapter presents the discussion of the findings of the study titled *Adjusting to Changes in the Intergenerational Care System: Care for the Elderly in Nigeria*. The discussion is structured around the research objectives and is aimed at interpreting the results in relation to existing literature, theoretical perspectives, and the broader socio-cultural context of Nigeria. All tables and figures are from the fieldwork raw data, 2025.

The analysis integrates the evidence and insights derived from the data obtained from a sample of respondents in ten wards across Epe Local Government Area, Lagos, Nigeria, to provide an understanding of how elderly Nigerians experience care, the changing patterns of intergenerational reciprocity, and their preferences for future care arrangements. Specifically, the discussion examines six core dimensions aligned with the following research objectives:

1. How the elderly perceive their current state of care.
2. Their perceptions of shifts in reciprocal care received from adult children.
3. The extent to which they can tolerate economic versus non-economic deprivation.
4. Their views on possible adjustments to disruptions in intergenerational care.
5. Their willingness to live in an elderly home if such services are available.
6. The influence of belief systems in shaping their attitudes toward care homes.

Through this structure, the chapter not merely restates the results but interprets them in the context of Nigeria's evolving socio-economic conditions, cultural expectations, and ongoing debates about the need for care for the elderly in the country. The aim is to understand the deficiencies and resilience of the existing intergenerational care system and to identify ways elderly care can be improved in the country based on the perception, preferences, and lived realities of the elderly population.

## 4.2 The socio-demographics of respondents

This section, comprising seven variables, presents the socio-demographics data obtained from the respondents. The location for this study is a microcosm of Nigerian society because it is generally agreed among Nigerians that Lagos State is the only place in the country where all ethnic nationalities that make up Nigeria are represented, much to the irritation of the Yoruba, who are indigenous to the place; other ethnic groups usually refer to Lagos as a no-man's land. Data from this study can therefore be considered a reflection of the socio-demographics of the Nigerian elderly.

**Table 4.2.1: The social-demographic attributes of the respondents**

| | ***Frequency*** | ***Percentage*** |
|---|---|---|
| ***V1. Age of respondents in years*** | | |
| 65 – 74 (Young old) | 103 | 51.5 |
| 75 – 84 (Middle old) | 68 | 34.0 |
| 85 – 89 (Oldest old) | 29 | 14.5 |
| ***V2. Gender*** | | |
| Male | 93 | 46.5 |
| Female | 107 | 53.5 |
| ***V3. Highest formal education completed*** | | |
| None | 37 | 18.5 |
| Primary | 57 | 28.5 |
| Secondary | 50 | 25.0 |
| Higher education | 56 | 28.0 |
| ***V4. Do you have a family member?*** | | |
| Yes | 195 | 97.5 |
| No | 5 | 2.5 |
| ***V5. Do you live with family member(s)?*** | | |
| Yes | 184 | 92.0 |
| No | 16 | 8.0 |
| ***V6. Who do you live with? **** | | |
| Daughter | 126 | 63.0 |
| Son | 117 | 58.5 |
| Another family member | 115 | 57.5 |
| Spouse | 81 | 40.5 |
| Non-family member | 44 | 22.0 |
| Alone | 17 | 8.5 |
| Other | 0 | 0.0 |

| ***V7. Source of Income**** | | |
|---|---|---|
| Support from family members | 154 | 77.0 |
| Support from non-family members | 107 | 53.5 |
| Owned a business | 84 | 42.0 |
| Pension | 76 | 38.0 |
| Return on previous investment | 32 | 16.0 |
| No reliable source of income | 25 | 12.5 |
| Paid employment | 5 | 2.5 |
| Other | 0 | 0.0 |
| ***Total*** | ***200*** | ***100.0*** |

Note: * Multiple-response choice question

In Table 4.2.1, the age distribution (v1) shows that the largest proportion of respondents (51.5%) is between 65 – 74 years, followed by 34.0% aged 75–84, and 14.5% aged 85–89. The mean and median ages are 74 and 73 years old, respectively. This indicates that the survey sample consists primarily of the "younger-old" group, where functional independence is relatively common but anticipates higher care needs in the near future when age-related vulnerabilities may begin to emerge. The presence of respondents across all three categories allows for comparisons of care expectations, willingness to accept alternative support, and decision-making dynamics across age groups.

The gender distribution (v2) is nearly balanced, with a slight female majority (53.5%) compared to males (46.5%), reflecting broader longevity patterns where women often outlive men. Education levels (v3) are mixed, with 28.5% attaining primary education, 28.0% completing higher education, 25.0% secondary education, and 18.5% having no formal education. This suggests a diverse literacy base, capable of influencing the communication of healthcare information and awareness of care options. An overwhelming majority of respondents (97.5%) reported having a family member (v4), while only 2.5% indicated they had none. This reinforces the central role of family in the lives of elderly individuals and highlights the cultural value placed on filial ties in elder care arrangements.

Household living arrangements (v5) reveal that 92% of respondents live with family members, while only 8.0% live alone. Among those co-residing (v6), 63% of the respondents live mainly with their daughter rather than their son or another family member, with 58.5% and 57.5%, respectively. The data further revealed that 8.5% and 22% of the elderly did not seem to prefer to

live alone or with non-family members. Overall, the data showed the prominence of multigenerational households. The data (v7) for no reliable source of income, 12.5%, and paid employment at 2.5% indicated that the elderly have a source of income, this is reflected in the percentage that indicated respondents rely more on family members (77%) and non-family members (53.5%) for a substantial part of their income while pension (38%) and owning a business (42%) represent a fairly reliable source of income. This demonstrates a blend of financial independence and reliance on external assistance, which could influence attitudes toward long-term care solutions.

### 4.3 The elderly's perception of care received from the people

This section, comprising twelve variables, presents the data obtained from the respondents regarding their perception of the care they received from different categories of people The data from Table 4.3.1 below revealed that children were primarily responsible for the elderly well-being, with 76%, highlighting daughters as predominantly responsible for the elderly care (v8) followed by their sons (65.5%), self-reliance (56.5%) and spousal support (33%), respectively. A small proportion of the respondents indicated their well-being relied on others outside of the categories mentioned above. These results show a significant reliance on children for elderly care, but also highlight that one in four elderly individuals depends on themselves. A slight majority (54%) have regular and significant healthcare needs (v9), while the others (46%) have minimal or no healthcare needs.

**Table 4.3.1: The perception of the respondents by the reciprocal care they received**

| | ***Frequency*** | ***Percentage*** |
|---|---|---|
| ***V8. Responsibility for your well-being lies with**** | | |
| Daughter | 152 | 76.0 |
| Son | 131 | 65.5 |
| Self | 113 | 56.5 |
| Spouse | 66 | 33.0 |
| Other | 18 | 9.0 |
| ***V9. Have healthcare needs*** | | |
| Significant needs | 19 | 9.5 |
| Regular needs | 89 | 44.5 |
| Minimal needs | 73 | 36.5 |
| No needs | 19 | 9.5 |

| | | |
|---|---|---|
| ***V10. Able to meet healthcare needs*** | | |
| Completely | 28 | 14.0 |
| Mostly | 111 | 55.5 |
| Somewhat | 52 | 26.0 |
| Not at all | 9 | 4.5 |
| ***V11. Describe your well-being*** | | |
| Very poor (e.g., with a condition requiring daily physical assistance) | 17 | 8.5 |
| Poor (e.g. with condition that does not require daily physical assistance) | 24 | 12.0 |
| Fair (e.g. relying on regular medication or medical check-up) | 64 | 32.0 |
| Good (e.g. occasionally needing medication or medical check-up) | 74 | 37.0 |
| Excellent (No need for regular or occasional medication or check-up) | 21 | 10.5 |
| ***V12. Advantages of multigenerational co-dwelling**** | | |
| Strengthened family bond | 127 | 63.5 |
| Reciprocal care (shared obligations) | 124 | 62.0 |
| Emotional support | 120 | 60.0 |
| Physical support | 107 | 53.5 |
| Sense of security | 78 | 39.0 |
| Other | 1 | 0.5 |
| ***V13. Major advantage in multi-generational co-dwelling*** | | |
| Strengthened family bond | 56 | 28.0 |
| Reciprocal care (shared obligations) | 55 | 27.5 |
| Sense of security | 41 | 20.5 |
| Emotional support | 25 | 12.5 |
| Physical support | 23 | 11.5 |
| ***V14. Disadvantages of multi-generational co-dwelling**** | | |
| Financial strains | 142 | 71.0 |
| Overcrowding | 117 | 58.5 |
| Intergenerational conflict/lifestyle mismatch | 91 | 45.5 |
| Family caregiver burnout | 85 | 42.5 |
| Lack of privacy/independence | 64 | 32.0 |
| Other | 1 | 0.5 |

| | | |
|---|---|---|
| ***V15. Major disadvantage in multi-generational co-dwelling*** | | |
| Financial strains | 94 | 47.0 |
| Overcrowding | 35 | 17.5 |
| Intergenerational conflict/lifestyle mismatch | 28 | 14.0 |
| Lack of privacy | 24 | 12.0 |
| Family caregiver burnout | 19 | 9.5 |
| ***V16. If respondents received any type of care from the family in the last 30 days*** | | |
| Yes | 180 | 90 |
| No | 20 | 10 |
| ***V17. Types of care received from family in the last 30 days**** | | |
| Financial | 156 | 78.0 |
| Food (e.g., availability/supplies) | 132 | 66.0 |
| Medical care (e.g., medication/hospital visits) | 124 | 62.0 |
| Physical (e.g., chores, being aided to eat, etc.) | 102 | 51.0 |
| Emotional (e.g., being visited, calls, etc.) | 96 | 48.0 |
| None | 15 | 7.5 |
| Other | 0 | 0.0 |
| ***V18. Rate the care you received from your family in the last 30 days*** | | |
| Lowest | 13 | 6.5 |
| Low | 18 | 9.0 |
| Average | 56 | 28.0 |
| High | 91 | 45.5 |
| Highest | 22 | 11.0 |
| ***Total*** | ***200*** | ***100.0*** |

Note: * Multiple-response choice question

From table 4.3.1 above, 55.5% of the respondents reported being able to meet their healthcare needs (v10) "mostly," while 14.0% could meet them "completely." However, 26.0% could only meet them "somewhat," and 4.5% could not meet their needs at all. This indicates that while most elderly individuals have relatively good access to healthcare, a segment experiences partial or inadequate healthcare support. Respondents rated their well-being across different levels (v11): 37.0% described it as good, 32.0% as fair, and 10.5% as excellent. On the other hand, 12.0% rated their well-being as poor, and 8.5% as very poor. These findings suggest that nearly 80% have a positive perception of their well-being (fair to excellent), but around 20% have vulnerable health conditions that require attention. More than 50.0% of the respondents affirmed a strengthened

family bond (63.5%), the reciprocal care (62.0%), emotional and physical support (60.0% and 53.5%) respectively, as the most commonly cited advantages in multigenerational co-dwelling (v12), while sense of security (39.0%) was considered the least advantage of them all. This showed that support, such as financial, physical, and emotional support, is the primary benefit of multigenerational co-dwelling for the elderly, while the sense of security aspect is secondary.

When asked to select the single most important advantage (v13), strengthened family bond (28%) and reciprocal care (27.5%) ranked highest, closely followed by sense of security (20.5%). Emotional support (12.5%) and physical support (11.5%) were identified by fewer respondents, though they remain notable aspects of co-dwelling. In a multiple-choice question, the primary disadvantage (v14) reported was financial constraints by 71.0% of the respondents, followed by overcrowding (58.5%), intergenerational conflict/lifestyle mismatch (45.5%), and Family caregiver burnout (42.5%). Lack of privacy/independence was considered a lesser disadvantage of the co-dwelling arrangement at 32% of the data analysed.

Furthermore, financial constraints were identified as the major disadvantage of multi-generational co-dwelling (v15) by nearly half of respondents (47.0%), while overcrowding stood a far distance as the second major challenge, at 17.5%. These findings suggest that while overcrowding and intergenerational conflicts were widely acknowledged in general responses, financial strain is perceived as the most critical single challenge when forced to choose one. For instance, Yan (2025) & Barbalet (2025) assert that when the state retreats into austerity policies, it leaves individuals to become more dependent on intergenerational family prosperity. The very high percentage (90.0%) confirms the centrality of family as the primary care provider (v16) for the elderly. The small minority who did not receive care may represent those who remain largely independent or who experience care gaps.

The chart in Figure 1 below, regarding the specific types of care provided by families (v17), shows that 78% of the respondents received financial support, representing the most common support received in the last 30 days, while food, medical care, physical care, and emotional care were received by 66%, 62% 51% and 48% of the respondents, respectively.

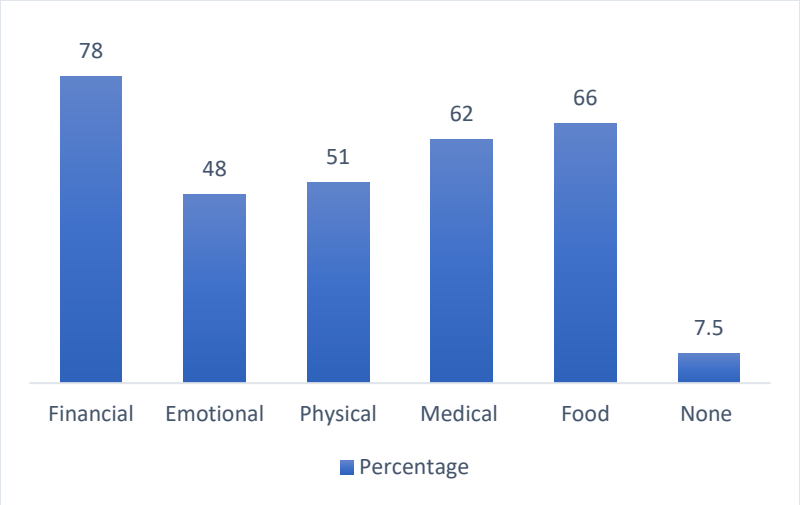


**Figure 1: Type of care from family in the last 30 days (v17)**

About 7.5% of the respondents did not receive any form of care or support in the last 30 days, highlighting the most vulnerable groups among the respondents. This distribution suggests that general, multi-dimensional care dominates family caregiving practices, while financial and food support remain important primary forms.

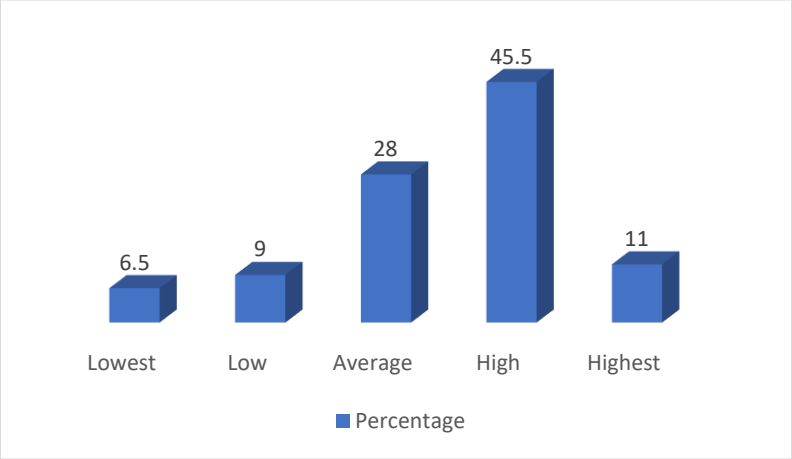


**Figure 2: Rate the care you received from your family in the last 30 days (v18)**

The chart in Figure 2 above presents how respondents rated the quality of family care (v18) on a scale of 1 – 5, i.e., from lowest to highest. 45.5% respondents rated it high, 11% rated it highest, totaling 56.5%, while 28% rated it average. The mean value of 3.46 also indicates moderately strong satisfaction with family caregiving.

## 4.4 Perception of respondents on care preferences, whether economic or non-economic

This section, comprising five variables, presents the data obtained from respondents regarding their care preferences between economic and non-economic support.

**Table 4.4.1 Importance of the provision of types of care in daily living (percentage and frequency)**

| ***V19. Importance of the provision of the following types of care in daily living*** | **Extremely important** | **Very important** | **Moderately important** | **Slightly important** | **Not important at all** | **Total** | **Mean Value** |
|---|---|---|---|---|---|---|---|
| **Finance** | 79.5<br>159 | 10.0<br>20 | 7.0<br>14 | 3.5<br>7 | -<br>- | 100.0<br>200 | 4.66 |
| **Personal Hygiene** | 58.5<br>117 | 24.5<br>49 | 15.0<br>30 | 2.0<br>4 | -<br>- | 100.0<br>200 | 4.40 |
| **Food supplies** | 53.5<br>107 | 38.0<br>76 | 7.0<br>14 | 1.5<br>3 | - | 100.0<br>200 | 4.44 |
| **Taking medication** | 48.5<br>97 | 34.0<br>68 | 13.5<br>27 | 3.0<br>6 | 1.0<br>2 | 100.0<br>200 | 4.26 |
| **Being visited/calls** | 40.5<br>81 | 42.0<br>84 | 13.0<br>26 | 3.5<br>7 | 1.0<br>2 | 100.0<br>200 | 4.18 |
| **Assistance in preparing meals** | 35.5<br>71 | 29.5<br>59 | 30.0<br>60 | 4.0<br>8 | 1.0<br>2 | 100.0<br>200 | 3.95 |
| **Being aided to walk** | 25.0<br>50 | 9.0<br>18 | 11.0<br>22 | 9.0<br>18 | 46.0<br>92 | 100.0<br>200 | 2.58 |
| **Being aided to eat (e.g., Challenges using their hands)** | 22.5<br>45 | 11.0<br>22 | 9.0<br>18 | 6.5<br>13 | 51.0<br>102 | 100.0<br>200 | 2.48 |

In Table 4.4.1 above, the importance of the provision of types of care in daily living (v19), financial support emerges as the highest priority of all care types, with 79.5% rating it extremely important. This suggests that economic resources are seen as the foundation for accessing and sustaining all other forms of care, from medical needs to social support. Personal hygiene is a top priority, with 58.5% of respondents rating it as extremely important, followed by food supplies, with 53.5%.

This reflects a strong preference for cleanliness and daily comfort. Combined, over 91% view access to food as a critical aspect of care. Assistance in preparing meals has a more balanced distribution of importance. This indicates that although cooking assistance is valued, many respondents may retain some independence in preparation or receive informal support from family members. In contrast, being aided to eat is rated much lower in importance, with a majority (51.0%) considering it not at all important. Being visited or called was rated by 42.0% and 40.5% as very important and extremely important, respectively. Furthermore, medication management is recognized as a crucial aspect of care, with 48.5% of respondents rating it as extremely important and 34.0% as very important. In contrast, being aided to walk is considered not important at all by 46.0% of the respondents, alongside being aided to eat at 51.0%. The mean value provided a summary of the findings, with financial support being considered as the most important (4.66) for daily living, while food and personal hygiene closely followed at 4.44 and 4.40, respectively. Medication and being visited are considered moderately important at 4.26 and 4.18, respectively, while aid in preparing meals, walking, and assistance in eating are considered of lesser importance for daily living at 3.95, 2.58, and 2.48, respectively.

From table 4.4.2 below, showing responses on whom the respondents have received the most support (v20), family dominates as the main source of all support investigated, for food (81.5%) financial support (80.5%), medical care (75.0%) emotional care (60.5%) and physical care (54.0%), This highlights family as the primary provider of support to the elderly, and suggests limited involvement of non-family in providing support.

Meanwhile, a considerable number of respondents indicated that neighbours (26.5%) were a source of physical support, suggesting that physical caregiving often involves nearby, accessible support networks. The mean value shows that the highest forms of support received from all sources are food supplies (4.62), financial support (4.55), and medical care (4.51), respectively. Emotional support ranked average (4.30), while physical support was the least form of support received from the people.

**Table 4.4.2: From whom the respondents have received the most support (percentage and frequency)**

| *V20. From whom have you received the most support?* | Family | Friends | Neighbours | Community | No one | Total | Mean value |
|---|---|---|---|---|---|---|---|
| **Food supplies** | 81.5<br>163 | 8.5<br>17 | 4.0<br>8 | 2.0<br>4 | 4.0<br>8 | 100.0<br>200 | 4.62 |
| **Financial support** | 80.5<br>161 | 6.5<br>13 | 4.5<br>9 | 4.5<br>9 | 4.0<br>8 | 100.0<br>200 | 4.55 |
| **Medical care** | 75.0<br>150 | 14.0<br>28 | 4.5<br>9 | -<br>- | 6.5<br>13 | 100.0<br>200 | 4.51 |
| **Emotional support** | 60.0<br>120 | 18.5<br>37 | 16.5<br>33 | 1.5<br>3 | 3.5<br>7 | 100.0<br>200 | 4.30 |
| **Physical support** | 54.0<br>108 | 15.0<br>30 | 26.5<br>53 | 2.0<br>4 | 2.5<br>5 | 100.0<br>200 | 4.16 |

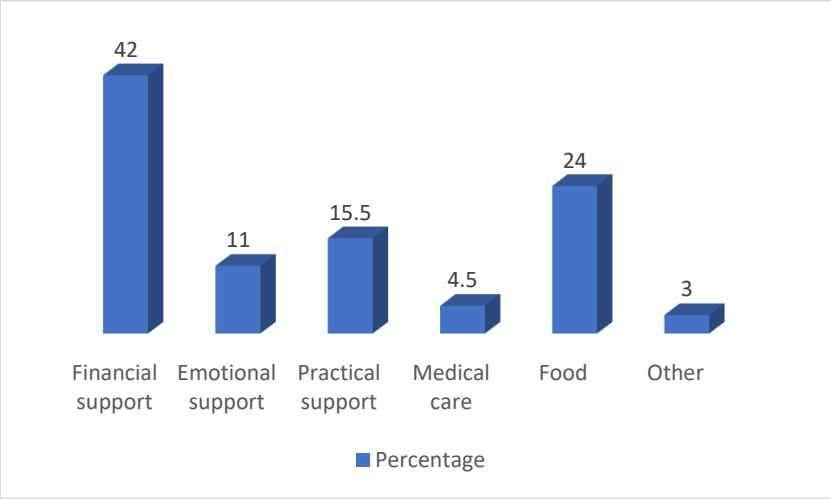


**Figure 3: Most valued support you have received from all people (v21)**

The chart in Figure 3 above identifies the most valued forms of support the respondents have received from all people (v21). Financial support ranked highest (42%), followed by food supplies (24%), and physical/practical help (15.5%). These findings emphasize that financial and nutritional stability are considered more critical than emotional or medical assistance, highlighting the priority of economic security in old age.

**Table 4.4.3: Importance of types of support to respondents' overall well-being (percentage and frequency)**

| ***V22. Importance of support to overall well-being in old age*** | **Very important** | **Important** | **Moderately important** | **Slightly important** | **Not important at all** | **Total** | **Mean value** |
|---|---|---|---|---|---|---|---|
| **Financial support** | 82.0<br>164 | 11.0<br>22 | 3.0<br>6 | 4.0<br>8 | -<br>- | 100.0<br>200 | 4.71 |
| **Medical support** | 79.5<br>159 | 14.5<br>29 | 4.5<br>9 | 1.5<br>3 | -<br>- | 100.0<br>200 | 4.72 |
| **Physical support** | 58.5<br>117 | 21.5<br>43 | 17.5<br>35 | 2.5<br>5 | -<br>- | 100.0<br>200 | 4.36 |
| **Emotional support** | 41.0<br>82 | 51.5<br>103 | 5.0<br>10 | 3.0<br>6 | 1.0<br>2 | 100.0<br>200 | 4.32 |

From Table 4.4.3 above, 82.0% of respondents consider financial support very important to their overall well-being in old age. When compared to the results from above, it re-emphasized the strong economic needs of the elderly and their dependence on consistent financial assistance. Also considered very important are medical care (79.5%), emotional support (41.0%), and physical support (58.5%). The emphasis on physical assistance shows that elderly individuals value help with daily activities to maintain quality of life. The mean value shows the respondents considered medical (4.72) and financial support (4.71) as the most important support for their well-being, while physical (4.36) and emotional support (4.32) are considered moderately important to the well-being of the respondents.

**Table 4.4.4: Most preferred type of support if they have to choose one option (v23)**

| ***V23. Most preferred type of support*** | **Frequency** | ***Percentage*** |
|---|---|---|
| Financial support | 107 | 53.5 |
| Emotional/social support (e.g., being visited by family members, calls, text messages, etc.) | 23 | 11.5 |
| physical/practical support (e.g., help with cooking, cleaning, being aided to eat, etc.) | 15 | 7.5 |
| Medical care support (e.g., medication, hospital visits) | 12 | 6.0 |
| Food (e.g., food availability/supplies) | 38 | 19.0 |
| I am not sure | 5 | 2.5 |
| ***Total*** | ***200*** | ***100.0*** |

Table 4.4.4 above shows that the majority of respondents (53.5%) preferred financial support as the most crucial form of assistance in old age (v23). This reflects the high value placed on financial stability and the ability to meet essential needs; as such, providing direct monetary assistance will be highly valued by the elderly. Food support is the second most preferred form of assistance (19.0%), indicating that access to consistent and adequate nutrition is a key factor in overall well-being.

## 4.5 Perception of respondents on the preferred mode of adjustment to changes in the intergenerational care system

The following section, comprising four variables, presents the data about respondents' preferred modes of adjustment to changes in the intergenerational care system.

**Table 4.5.1: The younger generation gives similar care as you gave to your previous generation (percentage and frequency)**

| ***V24. The younger generation gives similar care as you gave to your previous generation*** | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** | **Total** | **Mean value** |
|---|---|---|---|---|---|---|---|
| **Food supplies** | 67.5<br>135 | 13.0<br>26 | 5.5<br>11 | 12.0<br>24 | 2.0<br>4 | 100.0<br>200 | 4.34 |
| **Financial support** | 54.5<br>109 | 21.0<br>42 | 11.5<br>23 | 21.0<br>42 | 2.0<br>4 | 100.0<br>200 | 4.17 |
| **Medical care** | 53.5<br>107 | 24.5<br>49 | 7.5<br>15 | 12.5<br>25 | 2.0<br>4 | 100.0<br>200 | 4.15 |
| **Physical support** | 38.0<br>76 | 23.0<br>46 | 28.5<br>57 | 9.0<br>18 | 1.5<br>3 | 100.0<br>200 | 3.87 |
| **Emotional support** | 27.0<br>54 | 50.0<br>100 | 10.5<br>21 | 10.0<br>20 | 2.5<br>5 | 100.0<br>200 | 3.92 |

Table 4.5.1 above shows that the majority of respondents (67.5%) believed the younger generation would always provide food supplies. They also believed other types of support would always be provided, such as financial (54.5%), medical care (53.5%), physical care (38.0%), and emotional care (27.0%). The mean value shows food supplies (4.34) as the most typical type of care received

from the younger generation, in comparison to what they give to their previous generation. Financial (4.17) and medical support (4.15) are moderately similar, while emotional (3.92) and physical support (3.87) are the least similar among the five types of support analysed in the variable.

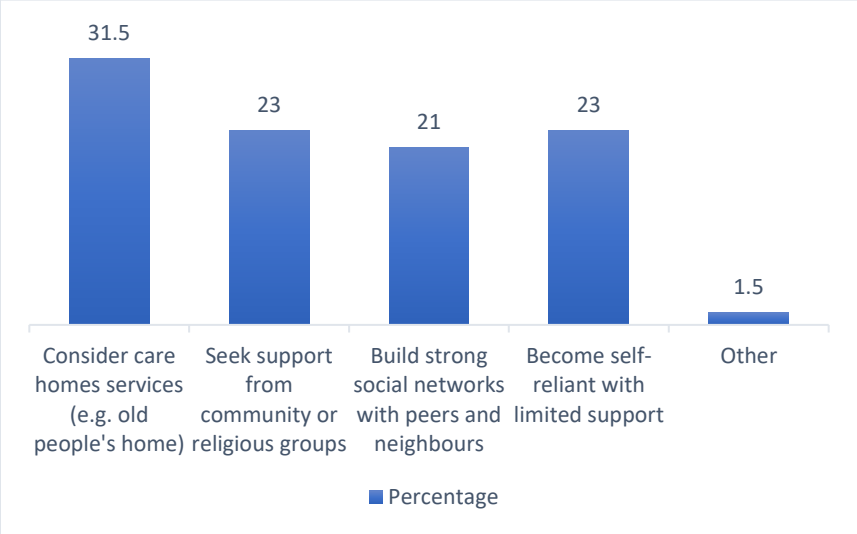


**Figure 4: Preferred adjustments if reciprocal care becomes less available (v26)**

The chart in Figure 4 shows the coping strategies that elderly respondents would prefer if family-based reciprocal care were to diminish (v26). The most common adjustment was considering care home services (31.5%). Other strategies included seeking support from community or religious groups (24.0%), becoming self-reliant with limited support (23.0%), and building strong social networks with peers and neighbours (21.0%). These results suggest openness to institutional and community-based care, alongside a strong emphasis on independence.

The results from Table 4.5.2 below showed varying levels of willingness among respondents (v27) to engage in peer caregiving or shared living programs as a means of support for the elderly. A significant proportion, 44.0%, indicated "Yes, maybe," suggesting an openness to the idea but with some reservations.

**Table 4.5.2: The preferred mode of adjustment to changes in the intergenerational care system**

| | ***Frequency*** | ***Percentage*** |
|---|---|---|
| ***V27. Willingness to participate in peer caregiving or shared living programs for elderly support*** | | |
| Surely | 60 | 30.0 |
| Yes, maybe | 88 | 44.0 |
| Not sure | 42 | 21.0 |
| No | 10 | 5.0 |
| ***V28. Essential considerations for managing reduced family caregiving*** | | |
| Access to affordable care home services (e.g., old people's home) | 61 | 30.5 |
| Maintaining close contact with family members, even if they cannot provide care | 60 | 30.0 |
| Emotional support and community connection | 31 | 15.5 |
| Learning new skills to stay independent | 48 | 24.0 |
| ***Total*** | ***200*** | ***100.0*** |

Furthermore, 30.0% of respondents stated they were "Surely" willing to participate, reflecting strong acceptance. On the other hand, 21.0% of respondents were "Not sure," highlighting uncertainty about the suitability or feasibility of such programs, while 5.0% indicated "No," showing complete unwillingness to participate. Overall, there is considerable potential acceptance, though concerns and hesitations remain.

When asked about essential considerations for managing reduced family caregiving (v28), respondents identified several key factors. Access to affordable care home services (30.5%) was the most frequently cited consideration, confirming the results in Figure 6 above and reflecting the need for institutional support when family caregiving is limited. Maintaining close contact with family members even when they are not able to provide care (30.0%) was as important, indicating that emotional connection and familial bonds remain a priority even when hands-on care is not feasible. Learning new skills to stay independent was selected by 24.0%, and emotional support and community connection (15.5%) were also emphasized.

## 4.6 Alternative opportunity for care

This section, comprising nine variables, discusses the respondents' views on the alternative opportunity for care that can be accommodated to replace the intergenerational care system.

**Table 4.6.1 Respondents' perception about alternative opportunities for care**

| | ***Frequency*** | ***Percentage*** |
|---|---|---|
| ***V29. Willingness to accept support from professional caregivers or volunteers*** | | |
| Very open | 83 | 41.5 |
| Somewhat open | 25 | 12.5 |
| Neutral | 35 | 17.5 |
| Reluctant | 57 | 28.5 |
| Not open at all | 0 | 0.0 |
| ***V30. Awareness about residential care options for the elderly in Nigeria*** | | |
| Yes | 168 | 84.0 |
| No | 32 | 16.0 |
| ***V31. Consideration of moving into a care home if cost is not a factor (ideal condition)*** | | |
| No | 47 | 23.5 |
| Not sure | 21 | 10.5 |
| Possibly | 99 | 49.5 |
| Yes, maybe | 22 | 11.0 |
| Surely | 11 | 5.5 |
| ***Total*** | ***200*** | ***100.0*** |

Table 4.6.1 above shows that a substantial proportion of respondents (41.5%) were very open to receiving care from professionals or volunteers (v29), reflecting a positive attitude toward formal or external caregiving options. Conversely, 28.0% were reluctant, indicating some reservations or cultural hesitations. These findings highlight that although there is a willingness to engage with professional care, a significant portion of the elderly population may require reassurance or trust-building initiatives.

Most respondents (84.0%) reported being aware of care home options for the elderly (v30), while 16.0% were not. This high level of awareness about institutional care facilities in Nigeria could influence openness to professional caregiving or the consideration of care homes.

When asked about moving into a care home under ideal conditions (v31), 49.5% of respondents said possibly, indicating cautious openness to institutional care. In contrast, 23.5% stated No,

demonstrating resistance. Overall, around two-thirds of respondents exhibit some form of willingness to consider care homes if conditions are favourable. Additionally, the study (v32) revealed that the majority of respondents (66.5%) preferred to receive minimum care at home by family, while 33.5% opted for maximum care in a care home. This indicates that most elderly individuals prioritize staying in familiar environments with family contact, even when the care they get is inadequate.

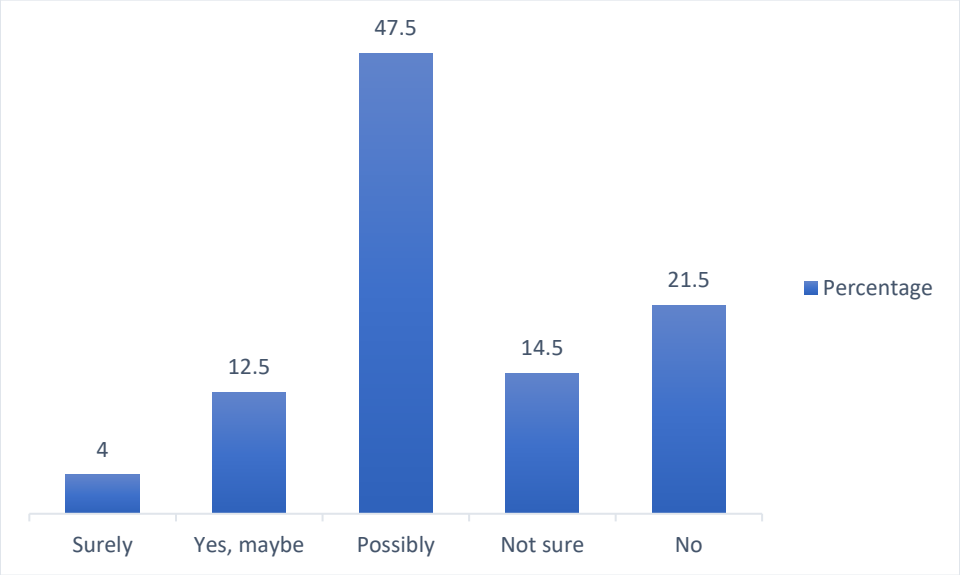


**Figure 5: Consideration for moving into a care home if family care is inadequate (v33)**

The chart in Figure 5 reveals mixed considerations (v33). The largest group (47.5%) selected "possibly," showing conditional openness to care homes, while 21.5% rejected the option outright, and 14.5% were unsure. These findings indicated some form of hesitation toward institutional care, but also showed a promising consideration for it as a fallback where (if) family caregiving is insufficient.

**Table 4.6.2: Respondents' perception of alternative opportunities for care (contd.)**

| | ***Frequency*** | ***Percentage*** |
|---|---|---|
| ***V34. Main concerns about living in a care home**** | | |
| Emotional/social isolation | 114 | 57.0 |
| Lack of family presence | 104 | 52.0 |
| No major concerns | 82 | 41.0 |
| Loss of independence | 79 | 39.5 |
| Cost of care | 57 | 28.5 |
| Quality of care | 51 | 25.5 |
| Other | 11 | 5.5 |
| ***V35. Family provides care needs*** | | |
| Completely | 19 | 9.5 |
| Mostly | 98 | 49.0 |
| Somewhat | 70 | 35.0 |
| Not at all | 13 | 6.5 |
| ***V36. Choice of care when family care is unavailable*** | | |
| Live independently with minimal assistance | 51 | 25.5 |
| Seek support from community services | 48 | 24.0 |
| Move into a care home | 48 | 24.0 |
| Live with a friend or relative | 27 | 13.5 |
| Hire a caregiver | 26 | 13.0 |
| ***Total*** | ***200*** | ***100.0*** |

Note: * Multiple-response choice question

Table 4.6.2 above shows the primary concern for respondents about living in a care home (v34), emotional and social isolation was the highest (57%), representing the foremost concern of the respondents, while lack of family presence (52%), and loss of independence (39.5%) are also some discouraging concerns, indicating that the ability to maintain self-determination and control over daily life is a major priority, as well as maintaining social bonds and connections even in institutional care. The percentage for cost of care (28.5%) indicated that it is a less prominent worry for them. A significant number of the respondents (41%) expressed no major concerns about living in care homes. Overall, the data underscore that independence and social connectedness are the most critical considerations for elderly individuals when evaluating options for care home services. Regarding the extent to which family meets care need (v35), 49.0% of respondents stated that their family mostly provides care, while 35.0% indicated somewhat, and only 9.5% reported that their

family provided care completely. A small proportion (6.5%) stated that their family does not at all provide care. These results reemphasize the findings from the previous section that family remains the primary source of support, although the level of assistance varies. When asked about preferred alternatives if family care is unavailable (v36), 25.5% of respondents chose to live independently with minimal assistance, reflecting a desire for self-sufficiency. Equal proportions (24.0%) preferred to move into a care home or seek support from community services, showing openness to institutional or organized external support, suggesting flexibility in care preferences.

**Table 4.6.3: Extent of agreement on care homes vs. family care quality (percentage and frequency)**

| ***V37. Extent of agreement on perception of care homes vs. family-based caregiving*** | **Strongly Agree** | **Agree** | **Neutral** | **Disagree** | **Strongly Disagree** | **Total** | **Mean value** |
|---|---|---|---|---|---|---|---|
| **Family-based caregiving strengthened family bonds** | 60.5<br>121 | 21.0<br>42 | 6.0<br>12 | 6.0<br>12 | 6.5<br>13 | 100.0<br>200 | 4.31 |
| **Family-based caregiving ensures shared obligations** | 39.5<br>79 | 42.0<br>84 | 7.0<br>14 | 7.0<br>14 | 4.5<br>9 | 100.0<br>200 | 4.06 |
| **Care homes promote hygiene** | 38.0<br>76 | 35.5<br>71 | 20.0<br>40 | 2.0<br>4 | 4.5<br>9 | 100.0<br>200 | 4.00 |
| **Care homes ensure social interaction** | 42.5<br>85 | 35.0<br>70 | 14.0<br>28 | 5.0<br>10 | 3.5<br>7 | 100.0<br>200 | 4.08 |
| **Intergenerational conflict is common in family-based caregiving** | 39.0<br>78 | 29.5<br>59 | 16.0<br>32 | 9.0<br>18 | 6.5<br>13 | 100.0<br>200 | 3.91 |
| **Family-based caregiving leads to caregiver fatigue** | 33.0<br>66 | 31.0<br>62 | 18.0<br>36 | 9.5<br>19 | 8.5<br>17 | 100.0<br>200 | 3.74 |
| **Placing a loved one in a care home is socially shameful** | 24.5<br>49 | 17.0<br>34 | 13.5<br>27 | 13.5<br>27 | 31.5<br>63 | 100.0<br>200 | 2.90 |
| **Placing a loved one in a care home leads to isolation/abandonment** | 28.5<br>57 | 10.5<br>21 | 15.0<br>30 | 21.5<br>43 | 24.5<br>49 | 100.0<br>200 | 2.97 |

From Table 4.6.3, the majority of respondents (60.5%) strongly agreed that family-based caregiving strengthens family bonds (v37). Responses were fairly balanced, with 39.5% strongly agreeing and 42.0% agreeing that family caregiving fosters shared obligations and responsibilities. These results suggest that respondents recognize family care as a way of distributing duties and promoting mutual responsibility across generations. Regarding the hygiene benefits of care homes, 38.0% strongly agreed and 35.5% agreed, which shows that the elderly consider there are health advantages to living in care homes. A notable 42.5% strongly agreed and 35.0% agreed that care homes enhance social interaction among the elderly. Respondents largely acknowledged the possibility of conflict in family caregiving, with 39.0% strongly agreeing and 29.5% agreeing. Regarding whether living in care homes leads to isolation or a feeling of abandonment, a larger percentage (46.0%) have some form of disagreement, while 37% have some form of agreement. This nudges the need for elderly care models that balance physical support with emotional and social connectivity. When the positive attributes of family caregiving and informal caregiving are compared using mean values, there is a major agreement (4.31) that family-based caregiving strengthens the bond, followed by care home ensures social interaction (4.08), family-based caregiving ensures shared obligations and responsibilities (4.06), and care home promotes hygiene (4.00), respectively. However, when the negative assumptions of family caregiving and informal caregiving are weighted, there is a major agreement that family-based caregiving is rife with intergenerational conflict (3.91), family caregiving leads to caregiver fatigue (3.74), placing a loved one in care home leads to abandonment (2.97), and placing a loved one in a care home is socially shameful (2.90).

## 4.7 The Elderly Decision Making

This section, comprising three variables, discusses the perceptions of the respondents regarding elderly decision-making with a view to understanding elderly agency in decisions that affect their lives. From Table 4.7.1 below, respondents expressed varying preferences regarding the involvement of their children in decision-making (v38). The largest group, 42.5%, preferred children's input sometimes, while 25.0% preferred it most times, and 15.0% indicated a few times. Only 5.0% preferred children's input always, and 12.5% indicated never. This suggests that while respondents value their children's input in decision-making, they also desire to maintain independence and do not expect constant involvement.

**Table 4.7.1: Respondents' perception about the locus of agency in the elderly decision-making process**

| | ***Frequency*** | ***Percentage*** |
|---|---|---|
| ***V38. The extent to which you prefer children's input in decisions*** | | |
| Always | 10 | 5.0 |
| Most times | 50 | 25.0 |
| Sometimes | 85 | 42.5 |
| A few times | 30 | 15.0 |
| Never | 25 | 12.5 |
| ***V39. Children's influence on decision-making*** | | |
| Always | 30 | 15.0 |
| Most times | 58 | 29.0 |
| Sometimes | 77 | 38.5 |
| A few times | 18 | 9.0 |
| Never | 17 | 8.5 |
| ***V40. Responsibility for deciding on care home living*** | | |
| Mine and my family's | 108 | 54.0 |
| Mine | 66 | 33.0 |
| My family's | 26 | 13.0 |
| ***Total*** | ***200*** | ***100.0*** |

Regarding actual influence (v39), 38.5% of respondents reported that children sometimes influence decisions, followed by 29.0% who stated influence occurs most times, 15.0% indicated influence always, 9.0% a few times, and 8.5% never. These results show that children have a meaningful but not absolute role in decision-making, reflecting a balance between elder independence and family input. When asked about responsibility for deciding on care home placement (v40), 54.0% indicated a joint decision with their family, while 33.0% indicated that they would make the decision themselves. Only 13.0% reported that the family maintained exclusive agency in making decisions for the elderly. The responses from this variable demonstrate a clear preference for collective decision-making, allowing for family involvement without entirely relinquishing personal agency.

## 4.8 Cross-tabulation Analysis

This section presents the results from the cross-tabulations done to understand how socio-economic characteristics such as age, gender, and education influence the respondents' perceptions about topics such as openness to receiving care from non-family members, preferred option if family care becomes less available, their agency and how their family might influence their decision to use care home if there is a need for it.

**Table 4.8.1: Cross-tabulations of Age versus Openness to receiving care from non-family members**

| Age group | Reluctant | Neutral | Somewhat open | Very open | Total |
|---|---|---|---|---|---|
| 65–74 (n=103, 51.5%) | 23 (22.3%) | 20 (19.4%) | 11 (10.7%) | 49 (47.6%) | 103 (100%) |
| 75–84 (n=68, 34.0%) | 23 (33.8%) | 12 (17.6%) | 9 (13.2%) | 24 (35.3%) | 68 (100%) |
| 85–89 (n=29, 14.5%) | 11 (37.9%) | 3 (10.3%) | 5 (17.2%) | 10 (34.5%) | 29 (100%) |
| **Total (N=200)** | **57 (28.5%)** | **35 (17.5%)** | **25 (12.5%)** | **83 (41.5%)** | **200 (100%)** |

Table 4.8.1 above shows that openness to receiving care from a non-family member is mixed. The young-old aged 65 – 74, who constituted 47.6% were open to receiving care from non-family members. Those in the middle-old category (75 - 84) are less open, with 35.3% very open and 33.8% reluctant. The highest reluctance (37.9%) was from the oldest old category (85 - 89), even though a close proportion (34.5%) expressed willingness to accept external care. Overall, 41.5% of the respondents expressed openness, while 28.5% were reluctant. The results showed that the likelihood of using a care home is high among the young old, showing the influence of modernity, while the likelihood is low among the oldest old, showing strong attachment to traditional family caregiving arrangements. This corroborates Yan's (2025) assertion that the modern family arrangement encompasses adaptive and transitional responses to changes in family experiences.

**Table 4.8.2: Cross-tabulations of Age versus Most preferred option if family could no longer provide care**

| Age group | Hire caregiver | Live with a friend/ relative | Live independently | Seek community support | Move into a care home | Total |
|---|---|---|---|---|---|---|
| 65–74 (n=103, 51.5%) | 16 (15.5%) | 11 (10.7%) | 29 (28.2%) | 26 (25.2%) | 21 (20.4%) | 103 (100%) |
| 75–84 (n=68, 34.0%) | 8 (11.8%) | 9 (13.2%) | 16 (23.5%) | 18 (26.5%) | 17 (25.0%) | 68 (100%) |
| 85–89 (n=29, 14.5%) | 2 (6.9%) | 7 (24.1%) | 6 (20.7%) | 4 (13.8%) | 10 (34.5%) | 29 (100%) |
| **Total (N=200)** | **26 (13.0%)** | **27 (13.5%)** | **51 (25.5%)** | **48 (24.0%)** | **48 (24.0%)** | **200 (100%)** |

The results from Table 4.8.2 showed that the most preferred alternative if the family could no longer provide care is independent living (25.5%), closely followed by community support and care homes option, each at 24.0%. Living independently is most preferred among the young old (65 - 74) at 28.2%. The middle-old preferred (75 - 84) preferred community support (26.5%) and care homes (25.0%), while the oldest-old (85 - 89), who had expressed highest reluctance (37.9%) in receiving care from non-family members in the previous section, now showed the strongest preference for care homes (34.5%), and preferred co-residence with friends or relatives (24.1%). It seems ageing and deprivation have the capacity to shift preferences towards receiving care through institutional support.

The results from Table 4.8.3 below indicate that children's role in decision-making for the elderly is significant. Among the young-old (65 - 74), 38.8% confirmed that their decision is sometimes influenced by the children, while 20.4% reported that it is most of the time. The middle-old (75 - 84) reported children's influence on their decision to be sometimes (48.5%), while some reported most of the time (30.9%). The oldest-old reported that children influence their decision most of the time (55.2%), and some reported always (20.7%). This suggests a gradual transfer of decision-making responsibility as ageing advances.

**Table 4.8.3: Cross-tabulations of Age versus Whether children influence respondents' decisions**

| Age group | Never | A few times | Sometimes | Most times | Always | Total |
|---|---|---|---|---|---|---|
| 65–74 (n=103, 51.5%) | 11 (10.7%) | 14 (13.6%) | 40 (38.8%) | 21 (20.4%) | 17 (16.5%) | 103 (100%) |
| 75–84 (n=68, 34.0%) | 5 (7.4%) | 2 (2.9%) | 33 (48.5%) | 21 (30.9%) | 7 (10.3%) | 68 (100%) |
| 85–89 (n=29, 14.5%) | 1 (3.4%) | 2 (6.9%) | 4 (13.8%) | 16 (55.2%) | 6 (20.7%) | 29 (100%) |
| **Total (N=200)** | **17 (8.5%)** | **18 (9.0%)** | **77 (38.5%)** | **58 (29.0%)** | **30 (15.0%)** | **200 (100%)** |

**Table 4.8.4: Cross-tabulations of Gender versus Most preferred option if family could no longer provide care**

| Group | Hire caregiver | Live with a friend/ relative | Live independently | Seek community support | Move into a care home | Total |
|---|---|---|---|---|---|---|
| Male (n=93) | 18 (19.4%) | 15 (16.1%) | 25 (26.9%) | 20 (21.5%) | 15 (16.1%) | 93 (100%) |
| Female (n=107) | 8 (7.5%) | 12 (11.2%) | 26 (24.3%) | 28 (26.2%) | 33 (30.8%) | 107 (100%) |
| **Total (N=200)** | **26 (13.0%)** | **27 (13.5%)** | **51 (25.5%)** | **48 (24.0%)** | **48 (24.0%)** | **200 (100%)** |

The results from Table 4.8.4 show that, among men, the most common choices are living independently (26.9%) or hiring a caregiver (19.4%), while among women, moving into a care home (30.8%) and seeking community support (26.2%) is the most preferred option if family can no longer provide care. Overall, the largest proportion of respondents across both genders (51.2%) prefer independence (25.5%), while care homes and community support are equally placed at 24.0%. Only a small proportion (13.0%) would consider hiring a caregiver. These findings suggest that men prefer to maintain independence or hire a caregiver, while women are more open to community support and care home options.

Table 4.8.5 below shows that decision-making around moving into a care home is primarily viewed as a shared responsibility. Over half of respondents (54.0%) prefer joint decision-making with their family, while about a third (33.0%) want the decision to be theirs alone. Only 13.0% would leave the decision entirely to the family. Men and women are similar in their preferences, though women are slightly more likely to defer to family than men (15.9% vs 9.7%). These results highlight the importance attached to consultation and family involvement.

**Table 4.8.5: Cross-tabulations of Gender versus Whose decision would it be if respondents were to go to a care home**

| Group | Mine | Mine and my family | My family | Total |
|---|---|---|---|---|
| Male (n=93) | 32 (34.4%) | 52 (55.9%) | 9 (9.7%) | 93 (100%) |
| Female (n=107) | 34 (31.8%) | 56 (52.3%) | 17 (15.9%) | 107 (100%) |
| **Total (N=200)** | **66 (33.0%)** | **108 (54.0%)** | **26 (13.0%)** | **200 (100%)** |

While independence remains valued, the preference for joint decision-making reflects cultural norms that see care as a collective family matter, where elders retain a voice but decisions are balanced with the input of close relatives. This aligns with Pan and Bian (2025), who assert that happiness within the family relies on family interactions and social capital.

**Table 4.8.6: Cross-tabulations of Education versus Whether respondents would move into a care home to live the rest of their lives**

| Education | No | Not sure | Possibly | Yes, maybe | Surely | Total |
|---|---|---|---|---|---|---|
| None (n=37) | 10 (27.0%) | 3 (8.1%) | 14 (37.8%) | 6 (16.2%) | 4 (10.8%) | 37 (100%) |
| Primary (n=57) | 13 (22.8%) | 2 (3.5%) | 33 (57.9%) | 8 (14.0%) | 1 (1.8%) | 57 (100%) |
| Secondary (n=50) | 11 (22.0%) | 8 (16.0%) | 25 (50.0%) | 1 (2.0%) | 5 (10.0%) | 50 (100%) |
| Higher (n=56) | 13 (23.2%) | 8 (14.3%) | 27 (48.2%) | 7 (12.5%) | 1 (1.8%) | 56 (100%) |
| **Total (N=200)** | **47 (23.5%)** | **21 (10.5%)** | **99 (49.5%)** | **22 (11.0%)** | **11 (5.5%)** | **200 (100%)** |

When asked about living the rest of their life in a care home under ideal conditions (Table 4.8.6), the largest share of respondents (49.5%) said they would possibly consider it, showing conditional openness. Definite willingness is rare, with only 5.5% answering surely. Differences appear across education: those with primary education are most open, with 57.9% saying possibly, while those without formal education are more divided, some showing higher levels of uncertainty or stronger rejection. Overall, the pattern points to cautious but growing acceptance of care homes across educational backgrounds. Respondents are open to the idea under some conditions, suggesting that affordability, quality, and trust in institutions are key factors in shaping their willingness.

**Table 4.8.7: Cross-tabulations of Education versus Consideration for moving into a care home to lessen family burden if family care is inadequate**

| Education | No | Not sure | Possibly | Yes, maybe | Surely | Total |
|---|---|---|---|---|---|---|
| None (n=37) | 9 (24.3%) | 8 (21.6%) | 10 (27.0%) | 6 (16.2%) | 4 (10.8%) | 37 (100%) |
| Primary (n=57) | 10 (17.5%) | 10 (17.5%) | 30 (52.6%) | 0 (0.0%) | 7 (12.3%) | 57 (100%) |
| Secondary (n=50) | 9 (18.0%) | 5 (10.0%) | 31 (62.0%) | 2 (4.0%) | 3 (6.0%) | 50 (100%) |
| Higher (n=56) | 15 (26.8%) | 6 (10.7%) | 24 (42.9%) | 10 (17.9%) | 1 (1.8%) | 56 (100%) |
| **Total (N=200)** | **43 (21.5%)** | **29 (14.5%)** | **95 (47.5%)** | **25 (12.5%)** | **8 (4.0%)** | **200 (100%)** |

Considering whether to move into a care home to reduce family burden if family care was inadequate (Table 4.8.7), nearly half of respondents (47.5%) said they would possibly do so. Around one in five (21.5%) would refuse outright, while smaller shares said yes, 12.5% said maybe, and 4.0% said surely. There are educational differences; those with secondary education are most open, with 62.0% answering possibly, while those with no formal education are more divided between rejection, uncertainty, and partial openness.

These results indicate that many elderly individuals are sensitive to the strain caregiving places on their families and are willing to consider institutional care to ease that burden. Education appears

to shape how such choices are approached, with more educated respondents expressing pragmatic openness, while less educated respondents remain cautious or undecided.

## 4.9 Discussion of Findings

This section discusses the findings of the study "Adjusting to Changes in Intergenerational Care System: Care for the Elderly in Nigeria". The discussion integrates univariate results with cross-tabulations to provide an interpretation of the perceptions, preferences, and decision-making processes of elderly Nigerians regarding care on the basis of sampled respondents in Epe Local Government Area, Lagos, Nigeria. The discussion focuses on perceptions of care, shifts in reciprocal obligations, economic and non-economic deprivation, coping strategies, openness to institutional care, and the influence of cultural and religious beliefs.

### *4.9.1 Perceptions of the State of Care*

Family remains the primary source of support for elderly individuals in Nigeria. Most respondents reported receiving multiple forms of family-based assistance, including financial, emotional, and medical support. Multigenerational co-residence was common, and satisfaction with family-provided care was generally high. This demonstrates that age-long intergenerational systems continue to play a central role in meeting both material and social needs of the elderly. The univariate data suggest that family care is not only accessible but trusted, providing assorted support rather than single-service assistance.

The results from cross-tabulations provide additional insight. Openness to non-family caregiving differed by age, with younger elders more willing to accept professional or volunteer assistance, whereas the oldest-old expressed the greatest reluctance. This indicates that traditional intergenerational care expectations remain strong among the oldest group, while younger elderly populations may be more receptive to adopting external care. Middle-aged elders (75–84) demonstrated moderate openness, reflecting a transitional stage in which exposure to alternative care arrangements begins to shape attitudes. These findings echo other studies that found younger elderly individuals adapting more readily to formalized care options, while older cohorts adhere to long-standing familial caregiving expectations (Akinrotile et al., 2020; Eke et al., 2024; Dwyer et al., 1994).

### *4.9.2 Shifts in Reciprocal Care Obligations*

The findings show that elders generally expect continued reciprocal support, particularly from children, though confidence in the sustainability of such support varies. While many elders reported that they could meet their healthcare needs to some degree, a substantial portion expressed uncertainty regarding future support. The cross-tabulation analyses highlight age-related trends in decision-making influence: younger elders maintained more autonomy, while the oldest-old increasingly relied on children for guidance and decision-making. This reflects the gradual transfer of caregiving authority and decision-making power as dependency increases, confirming recent evidence that adult children often assume more responsibility in care planning as their parents age (Imoh, 2022; Pan & Bian, 2025).

These findings also align with the concept of intergenerational reciprocity. Despite emerging challenges such as urban migration and smaller household sizes, the principle of familial obligation continues to guide care practices, though socio-economic and demographic changes are gradually reshaping the reliability of these obligations (Tanyi et al., 2018; Imoh, 2022; Yan, 2025).

### *4.9.3 Economic and Non-Economic Deprivation*

Financial support was the most valued type of assistance among respondents, followed by food, emotional, and medical support. This prioritization underscores the critical role of material resources in ensuring health, nutrition, and overall well-being. These findings are consistent with recent studies that emphasize the centrality of economic resources in shaping care relationships and autonomy among older adults (Cleland et al., 2021; Gureje et al., 2008). Financial security enables older adults to exercise choice and maintain dignity, while poverty often intensifies dependency and influences power dynamics within households.

### *4.9.4 Coping Adjustments to Disruptions in Care*

The data revealed that elders employ diverse strategies to cope when family care is limited. Common approaches included independent living, seeking community or religious support, peer networking, and consideration of care-home arrangements. Many respondents expressed willingness to engage in shared caregiving or peer-living arrangements, provided conditions such as family contact, hygiene, and autonomy were preserved.

The cross-tabulation analyses further revealed that education influenced coping choices. Those with a form of education were more open to organized care options, while those without an education preferred family-driven arrangements. Gender differences were also observed, with men favouring hiring a caregiver or self-reliant solutions, and women showing greater acceptance of community support and care-home options. These findings highlight the nuanced and adaptive strategies that elderly individuals employ, reflecting a careful negotiation between preference, necessity, and cultural expectations (Ezulike et al., 2024; Adamek et al., 2022; Akinrotile et al., 2020; Cadmus, 2020).

### *4.9.5 Openness to Institutional Care*

While many respondents preferred minimal family care at home, a subset considered maximum institutional care. Concerns about institutional care focused on loss of independence and social disconnection, though benefits such as hygiene and structured routines were acknowledged. Education increased openness, but did not eliminate cultural and relational concerns. This ambivalence reflects global trends in elderly care, where material and clinical advantages of institutions are balanced against emotional and social costs (Oluwagbemiga & Tiwalade, 2017; Artner, 2018).

### *4.9.6 Influence of Belief Systems*

Cultural and religious beliefs strongly influenced elder attitudes toward care. Family caregiving was widely perceived as a means of strengthening family bonds and fulfilling indebted-reciprocity obligations, reinforcing the principle of reciprocity. Shared decision-making was common, allowing elders to balance autonomy with family expectations. The cross-tabulation analysis showed that women were more likely to be involved in children's care-related decisions than men. Religious and cultural narratives further shaped attitudes toward institutional care, with some respondents associating it with abandonment or neglect (Tzai and Dzorgbo, 2012).

The findings highlight the enduring role of cultural norms and belief systems in shaping care preferences, showing that elder care is not merely a logistical matter but one deeply embedded in social, moral, and spiritual frameworks. Understanding these dimensions is crucial for interpreting care choices and willingness to consider non-family-based options.

# CHAPTER FIVE

# CONCLUSION

The study provides an in-depth examination of how elderly Nigerians perceive and navigate changes in intergenerational care systems. Efforts were made to ensure diversity; it is possible that the sample drawn was not completely representative of the elderly in the study area. As such, the findings should be generalized with caution beyond the study area. The field interactions were spontaneous, yet respondents had complete agency to choose from exhaustive responses; a mechanism was put in place, using "other" in the instrument to ensure respondents provided all their perceptions about the subject. In all, the researcher explores the best practices to arrive at the findings for this study.

Family remains the cornerstone of support, offering economic and non-economic assistance, with multigenerational co-residence ensuring proximity and continuous care. The combined univariate and cross-tabulation analyses reveal that elderly Nigerians from the sampled area exhibit diverse patterns of care preference, decision-making, and coping strategies, shaped by age, education, and cultural norms. Economic resources emerged as a critical determinant of agency and access to care, with financial security enabling choice and reducing dependence on children. Coping strategies, such as community support, peer networking, and selective acceptance of care homes, reveal pragmatic approaches that elders employ to maintain dignity and well-being. Overall, these findings demonstrate that elderly care in Nigeria is dynamic, adaptive, and culturally sensitive, revealing a careful balance between autonomy, family involvement, and openness to formal care services. The findings demonstrate that effective eldercare systems in Nigeria must recognise and accommodate these variations, balancing traditional familial roles with emerging preferences for formal care options.

The study concludes that intergenerational care for the elderly in Nigeria remains predominantly family-based, but significant variations exist across age groups, socio-economic status, and educational levels. Younger elders are more open to professional and community-based care arrangements, whereas the oldest-old rely heavily on children and institutionalized support as dependency increases. Age, gender, and education strongly influence the capacity for independent decision-making, access to care, and willingness to consider alternative caregiving arrangements.

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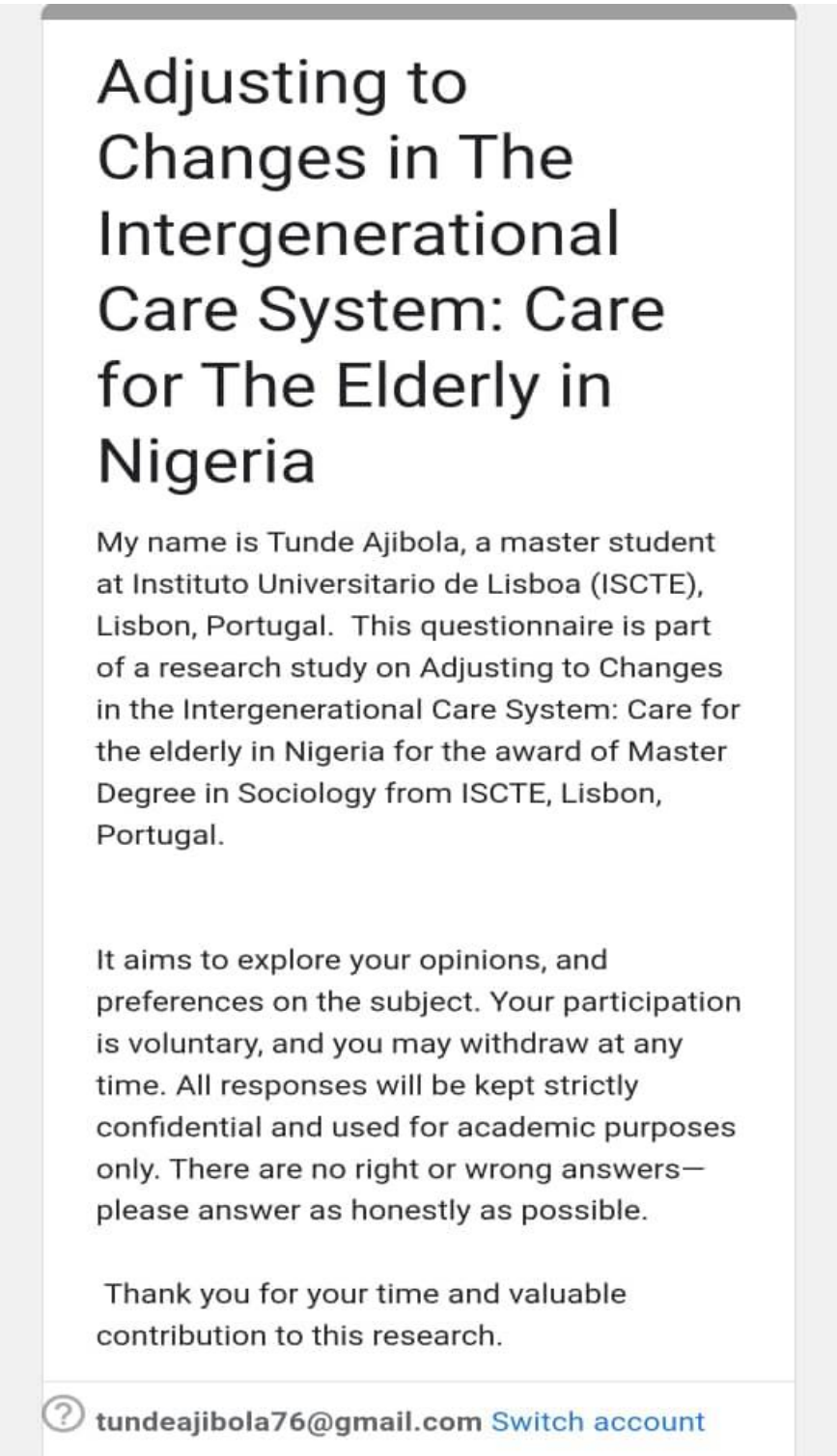
**APPENDIX A: The Research Instrument**



# Adjusting to Changes in The Intergenerational Care System: Care for The Elderly in Nigeria

My name is Tunde Ajibola, a master student at Instituto Universitario de Lisboa (ISCTE), Lisbon, Portugal. This questionnaire is part of a research study on Adjusting to Changes in the Intergenerational Care System: Care for the elderly in Nigeria for the award of Master Degree in Sociology from ISCTE, Lisbon, Portugal.

It aims to explore your opinions, and preferences on the subject. Your participation is voluntary, and you may withdraw at any time. All responses will be kept strictly confidential and used for academic purposes only. There are no right or wrong answers—please answer as honestly as possible.

Thank you for your time and valuable contribution to this research.

tundeajibola76@gmail.com Switch account

**Date** *

Date

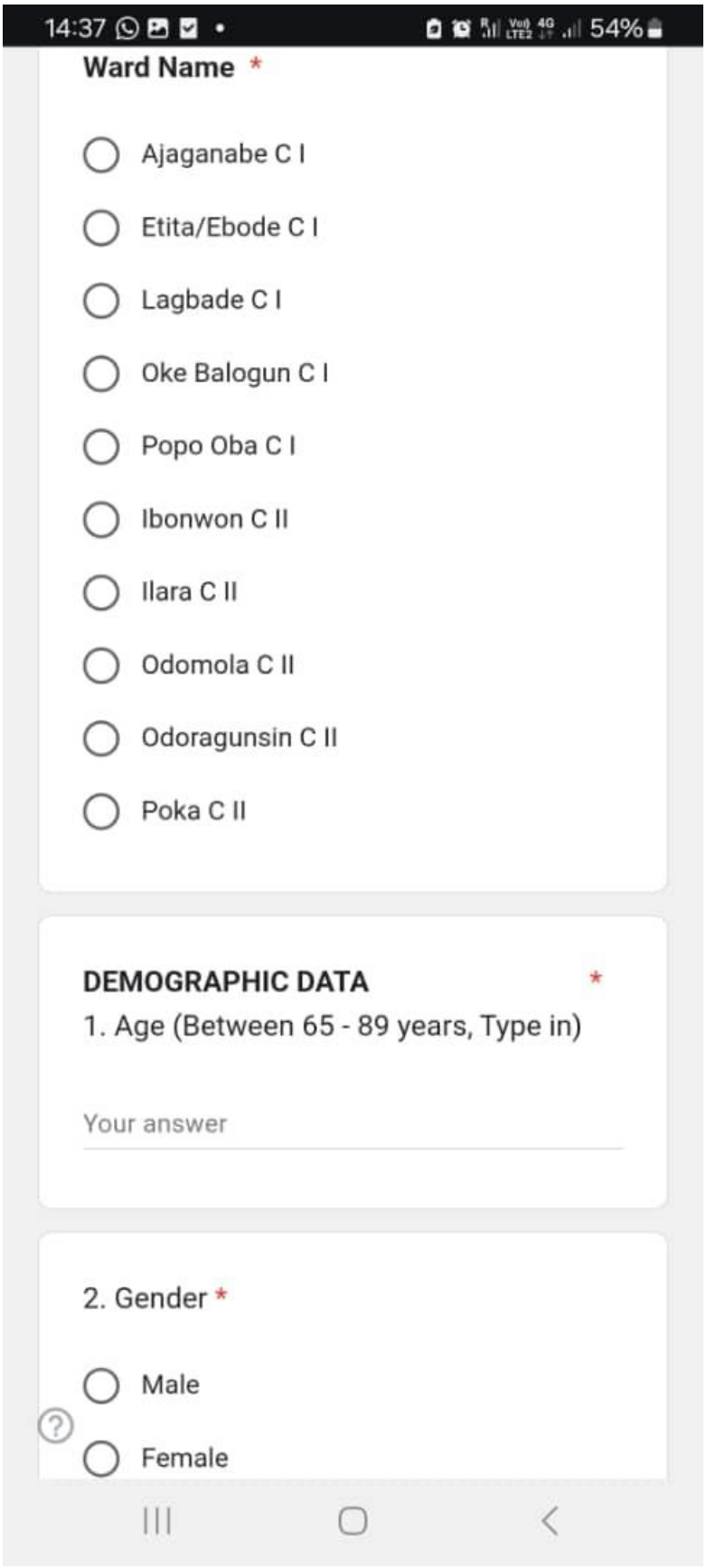
mm/dd/yyyy

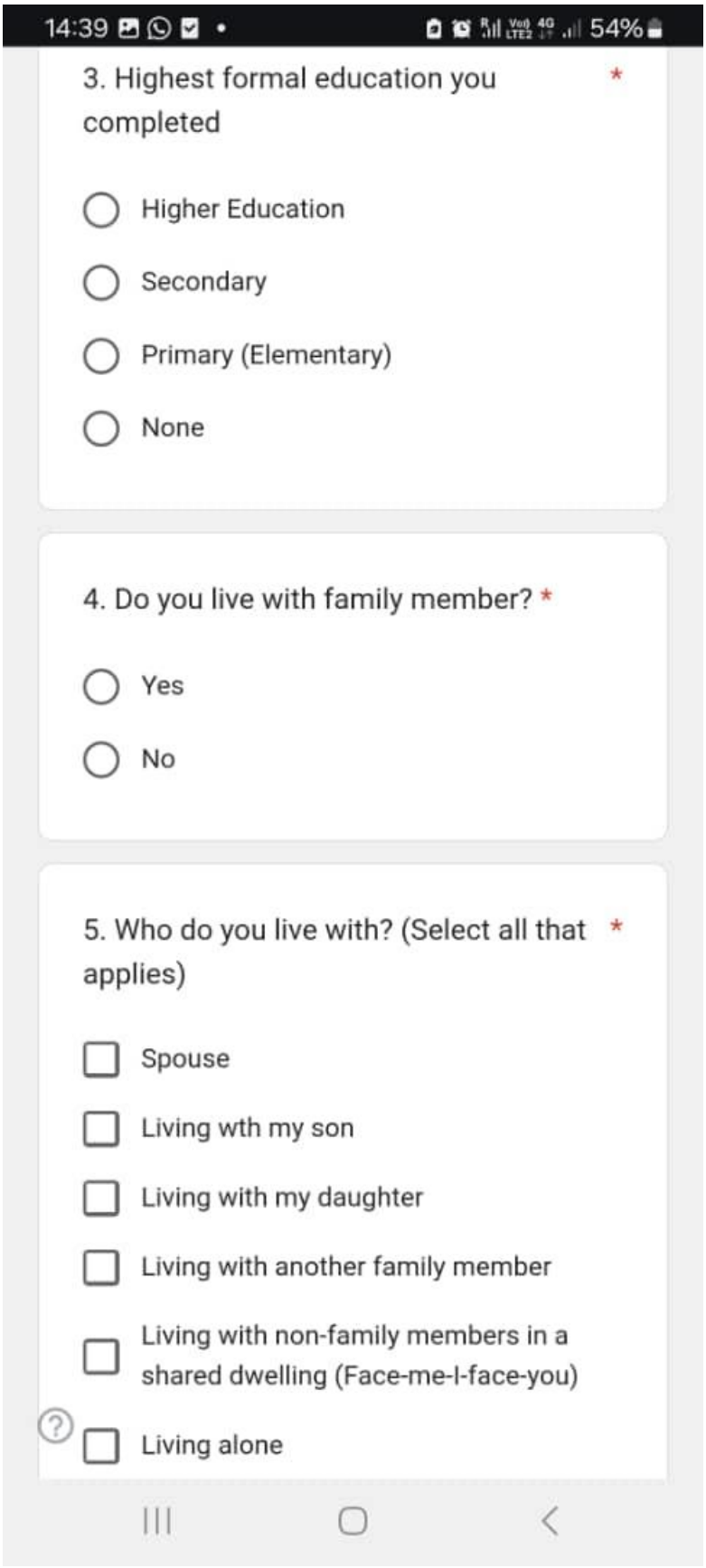
**FA** *

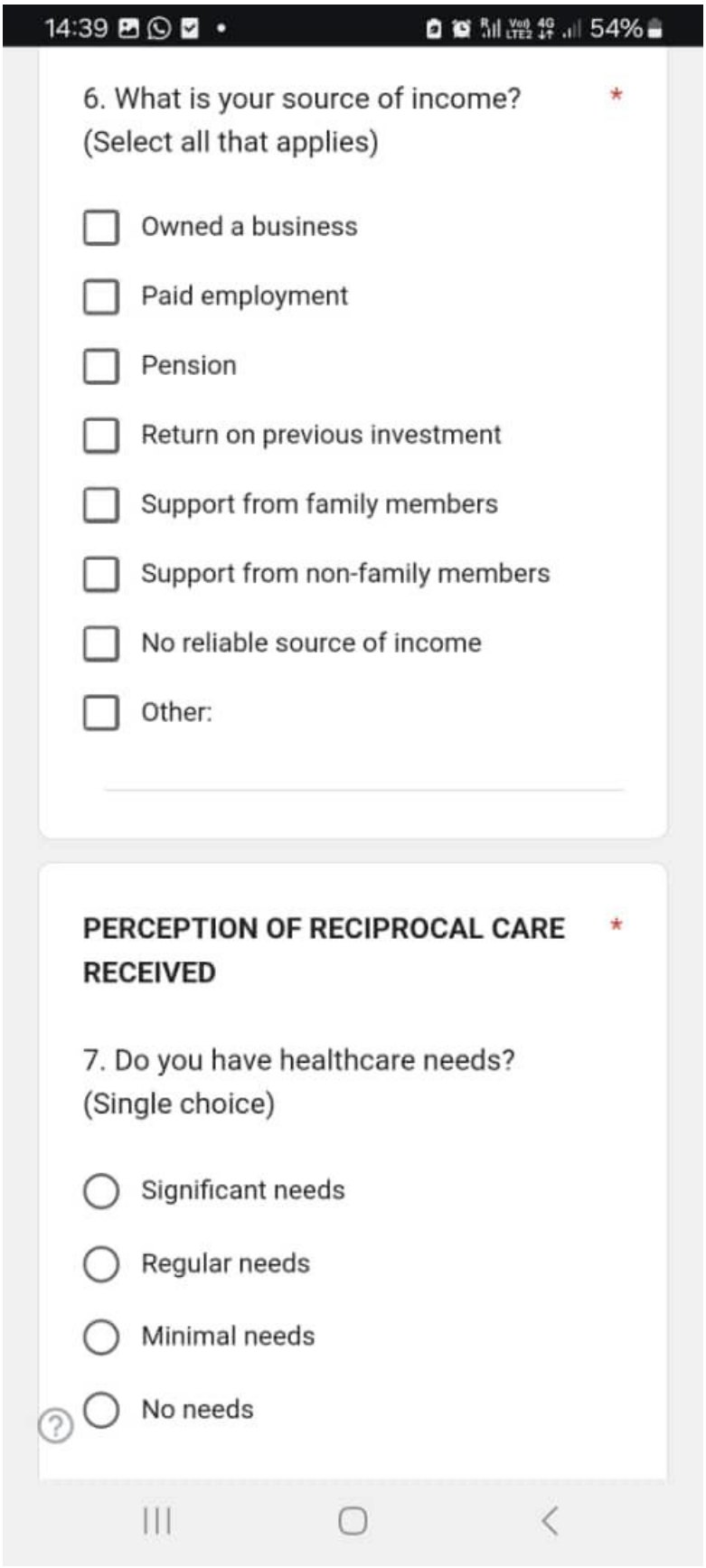
| | Alaba | Elizabeth | Festus | Mabel | Mariam |
|---|---|---|---|---|---|
| Name of Field Assistant | ○ | ○ | ○ | ○ | ○ |

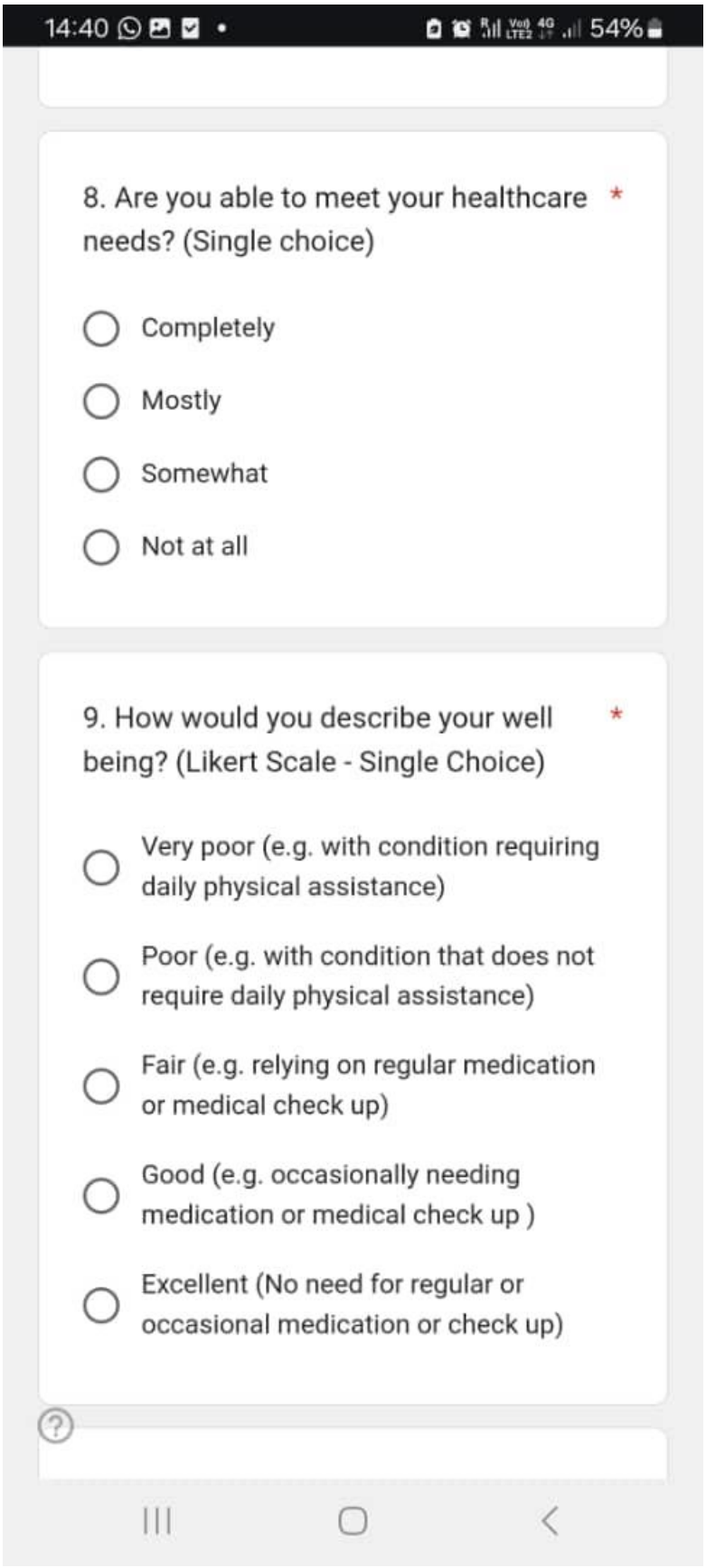
**Constituency** *

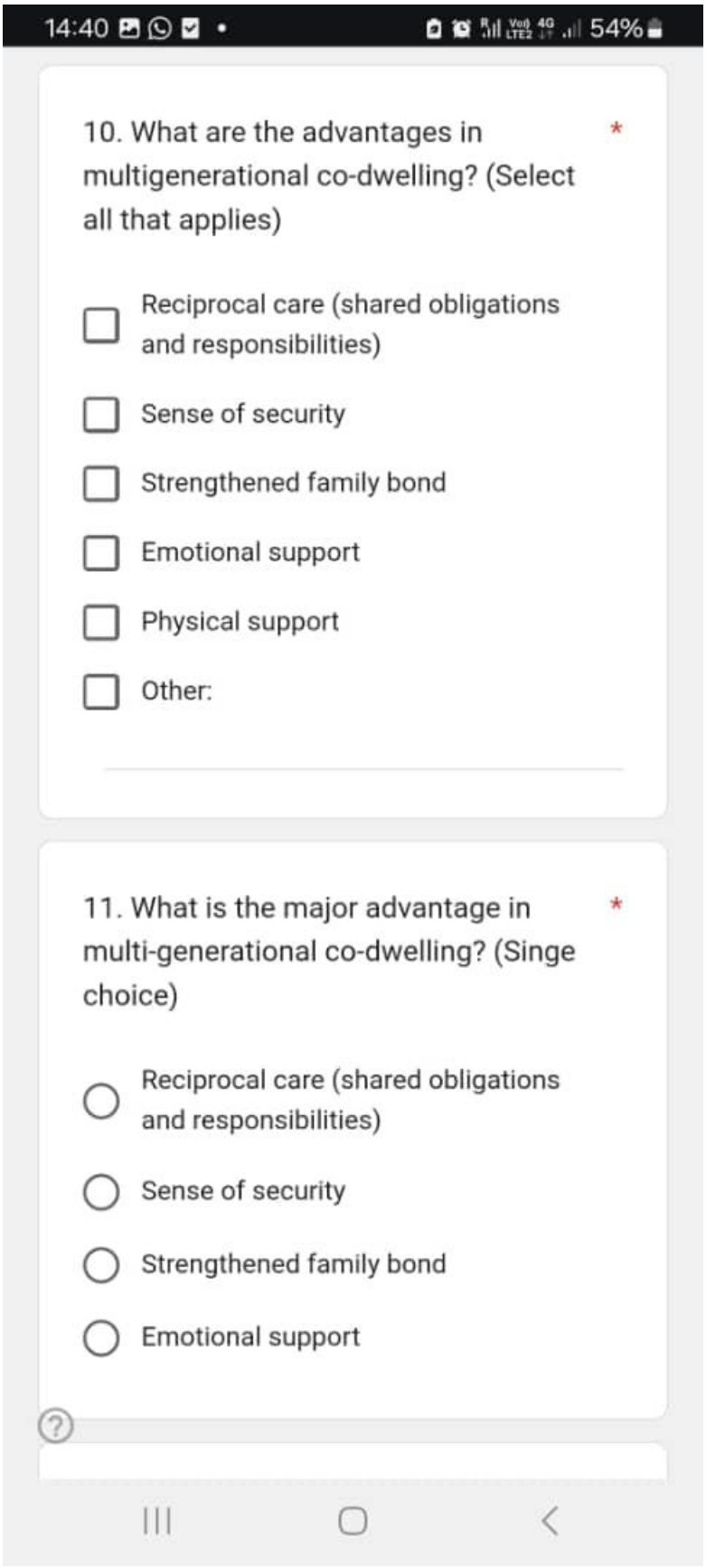
| | I | II |
|---|---|---|
| Constituency | ○ | ○ |

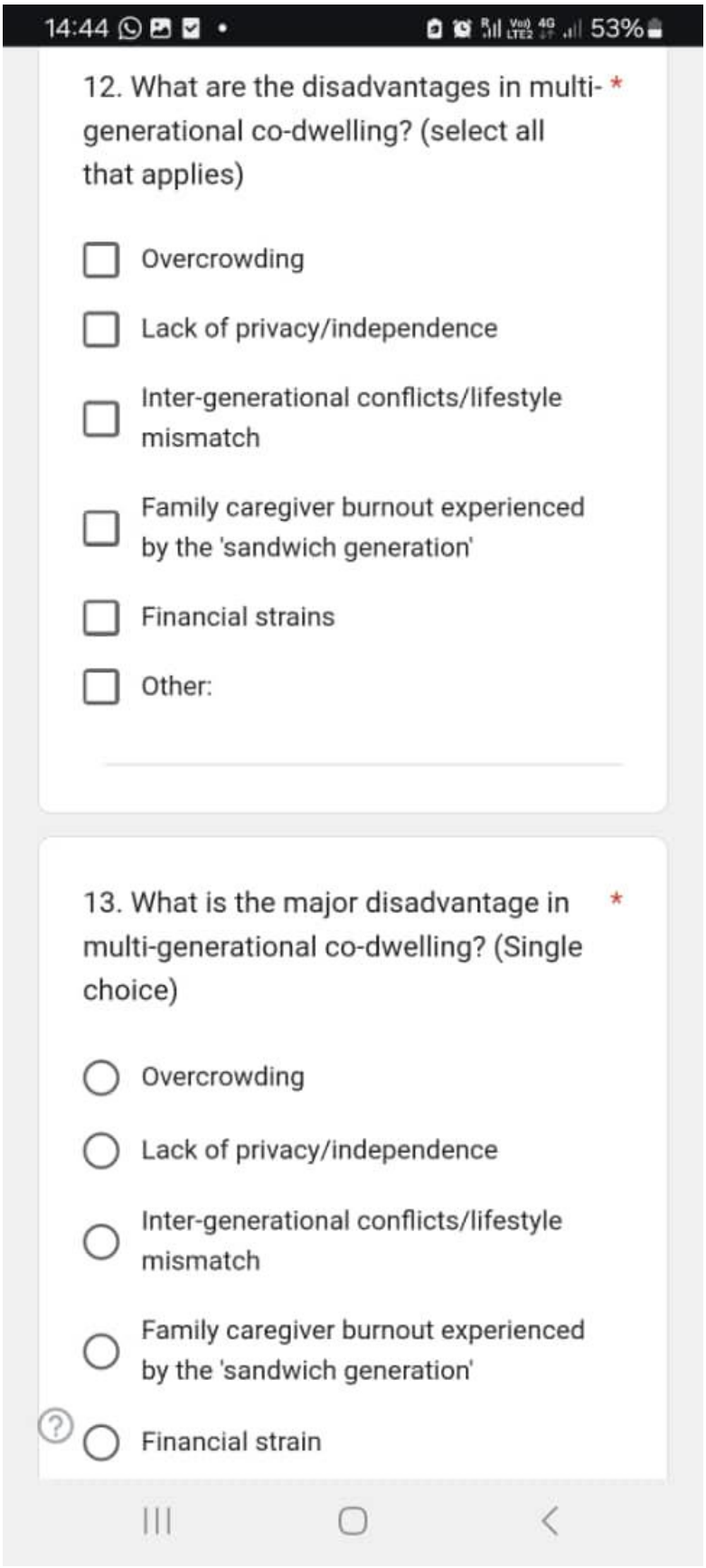

14:37
54%
Ward Name *
Ajaganabe C I
Etita/Ebode C I
Lagbade C I
Oke Balogun C I
Popo Oba C I
Ibonwon C II
Ilara C II
Odomola C II
Odoragunsin C II
Poka C II
DEMOGRAPHIC DATA *
1. Age (Between 65 - 89 years, Type in)
Your answer
2. Gender *
Male
Female

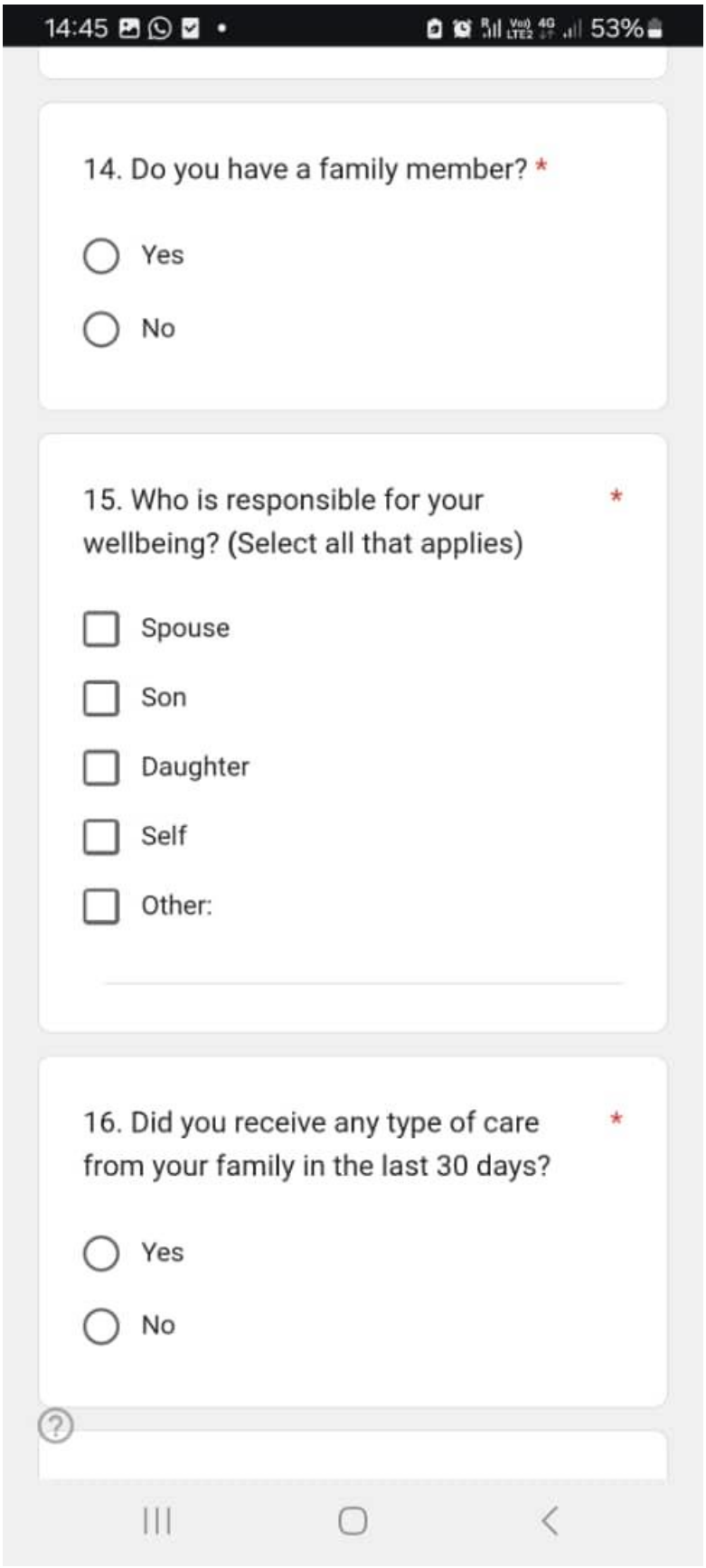

14:39
54%
3. Highest formal education you completed *
Higher Education
Secondary
Primary (Elementary)
None
4. Do you live with family member? *
Yes
No
5. Who do you live with? (Select all that applies) *
Spouse
Living wth my son
Living with my daughter
Living with another family member
Living with non-family members in a shared dwelling (Face-me-I-face-you)
Living alone


14:39
54%
6. What is your source of income? *
(Select all that applies)
Owned a business
Paid employment
Pension
Return on previous investment
Support from family members
Support from non-family members
No reliable source of income
Other:
PERCEPTION OF RECIPROCAL CARE RECEIVED *
7. Do you have healthcare needs?
(Single choice)
Significant needs
Regular needs
Minimal needs
No needs


14:40
54%
8. Are you able to meet your healthcare needs? (Single choice) *
Completely
Mostly
Somewhat
Not at all
9. How would you describe your well being? (Likert Scale - Single Choice) *
Very poor (e.g. with condition requiring daily physical assistance)
Poor (e.g. with condition that does not require daily physical assistance)
Fair (e.g. relying on regular medication or medical check up)
Good (e.g. occasionally needing medication or medical check up )
Excellent (No need for regular or occasional medication or check up)


14:40
54%
10. What are the advantages in multigenerational co-dwelling? (Select all that applies) *
Reciprocal care (shared obligations and responsibilities)
Sense of security
Strengthened family bond
Emotional support
Physical support
Other:
11. What is the major advantage in multi-generational co-dwelling? (Singe choice) *
Reciprocal care (shared obligations and responsibilities)
Sense of security
Strengthened family bond
Emotional support


14:44
53%
12. What are the disadvantages in multi-generational co-dwelling? (select all that applies) *
Overcrowding
Lack of privacy/independence
Inter-generational conflicts/lifestyle mismatch
Family caregiver burnout experienced by the 'sandwich generation'
Financial strains
Other:
13. What is the major disadvantage in multi-generational co-dwelling? (Single choice) *
Overcrowding
Lack of privacy/independence
Inter-generational conflicts/lifestyle mismatch
Family caregiver burnout experienced by the 'sandwich generation'
Financial strain


14:45
53%
14. Do you have a family member? *
Yes
No
15. Who is responsible for your wellbeing? (Select all that applies) *
Spouse
Son
Daughter
Self
Other:
16. Did you receive any type of care from your family in the last 30 days? *
Yes
No

17. What types of care did you receive from your family in the last 30 days? (Select all that applies) *

- [ ] Financial
- [ ] Emotional (e.g. being visited, calls, text messages, etc.)
- [ ] Physical (e.g. cleaning, cooking, chores, being aided to eat, etc.)
- [ ] Medical care (e.g. medication, hospital visits)
- [ ] Food (e.g. availability/supplies)
- [ ] None
- [ ] Other: _____

18. How can you rate the care you received from your family in the last 30 days? (1 being the lowest while 5 is the highest) *

| | 1 | 2 | 3 | 4 | 5 | |
|---|---|---|---|---|---|---|
| Lowest | ○ | ○ | ○ | ○ | ○ | Highest |

19. How important are the provision of the following types of care for your daily living? (Likert Grid - Answer all)

| | Not at all | Slightly | Moderate | Very Important | Extremely Important |
|---|---|---|---|---|---|
| Personal hygiene | ◯ | ◯ | ◯ | ◯ | ◯ |
| Food supplies | ◯ | ◯ | ◯ | ◯ | ◯ |
| Assistance preparing meals | ◯ | ◯ | ◯ | ◯ | ◯ |
| Being aided to eat (e.g. challenges using their hands) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Being visited/calls | ◯ | ◯ | ◯ | ◯ | ◯ |
| Taking medication | ◯ | ◯ | ◯ | ◯ | ◯ |
| Being aided to walk | ◯ | ◯ | ◯ | ◯ | ◯ |
| Finance | ◯ | ◯ | ◯ | ◯ | ◯ |

20. From whom have you received the following support most? (Likert Grid - Answer all) *

| | No one | Community | Neighbours | Friends | Family |
|---|---|---|---|---|---|
| Financial support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Emotional support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Physical support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Medical care support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Food (e.g. availability/supplies) | ◯ | ◯ | ◯ | ◯ | ◯ |

21. What is the most valued support you have received from all people? (Single choice) *

- ◯ Financial support
- ◯ Emotional support (e.g. being visited, calls, text messages, etc.)
- ◯ Physical/Practical help (e.g. cleaning, cooking, outdoor event, being aided to eat, etc.)
- ◯ Medical care (e.g. medication, hospital visits, etc.)
- ◯ Food (food availability/supplies)
- ◯ Other: _____

22. How important are the following support to your overall wellbeing in old age? * (Likert Grid - Answer all)

| | Not important at all | Slightly important | Moderately important | Important | Very important |
|---|---|---|---|---|---|
| Financial support | ○ | ○ | ○ | ○ | ○ |
| Emotional (e.g. being visited) | ○ | ○ | ○ | ○ | ○ |
| Physical (e.g. help with chores) | ○ | ○ | ○ | ○ | ○ |
| Medical care (e.g. medication, hospital visits) | ○ | ○ | ○ | ○ | ○ |

23. If you would only receive one type of support, which would you prefer? (Single choice) *

- ◯ Financial support
- ◯ Emotional/social support (e.g. being visited by family members, calls, text messages, etc)
- ◯ physical/practical support (e.g. help with cooking, cleaning, being aided to eat, etc.)
- ◯ Medical care support (e.g. medication, hospital visits)
- ◯ Food (e,g food availability/supplies)
- ◯ I am not sure

**PREFERRED MODE OF ADJUSTMENT TO CHANGES IN INTERGENERATIONAL CARE** *

24. Do you think the younger generation gives you the kind of (similar) care you gave to your previous generation? (Likert Grid - Answer all)

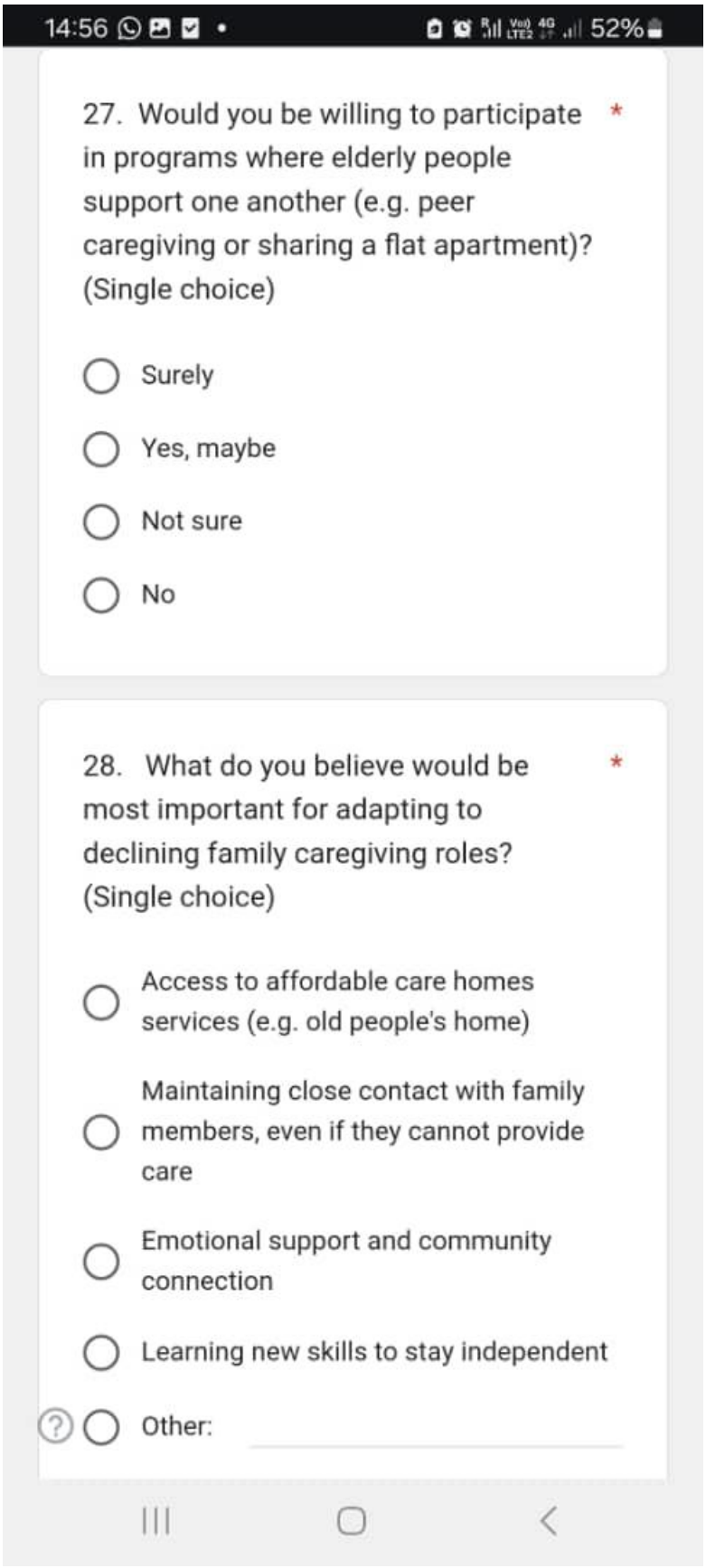
| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Financial support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Emotional support (e.g. visits, calls) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Physical support (chores) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Medical support (e,g, medication) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Food (availability/supplies) | ◯ | ◯ | ◯ | ◯ | ◯ |

25. Do you think the younger generation gives you the quality of care you gave to your previous generation? (Likert Grid - Answer all) *

| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Financial support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Emotional support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Physical/attention support | ◯ | ◯ | ◯ | ◯ | ◯ |
| Medical support (e.g. medication) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Food (availability/supplies) | ◯ | ◯ | ◯ | ◯ | ◯ |

26. If reciprocal care to you becomes less available, how would you prefer to adjust to this deficiency? (Single choice) *

- ◯ Consider care homes services (e.g. old people's home)
- ◯ Seek support from community or religious groups
- ◯ Build strong social networks with peers and neighbours
- ◯ Become self-reliant with limited support
- ◯ Other: _____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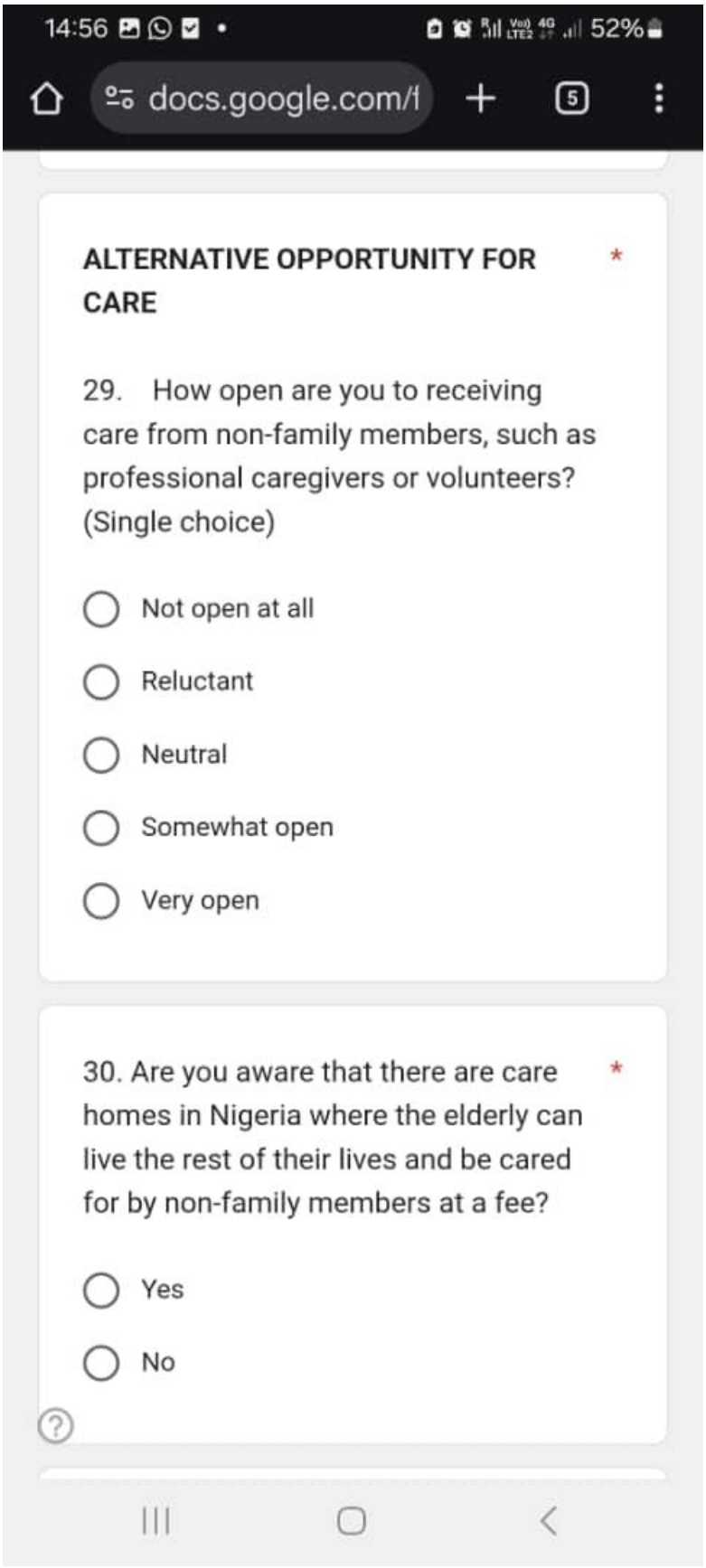
27. Would you be willing to participate in programs where elderly people support one another (e.g. peer caregiving or sharing a flat apartment)? (Single choice) *
Surely
Yes, maybe
Not sure
No
28. What do you believe would be most important for adapting to declining family caregiving roles? (Single choice) *
Access to affordable care homes services (e.g. old people's home)
Maintaining close contact with family members, even if they cannot provide care
Emotional support and community connection
Learning new skills to stay independent
Other: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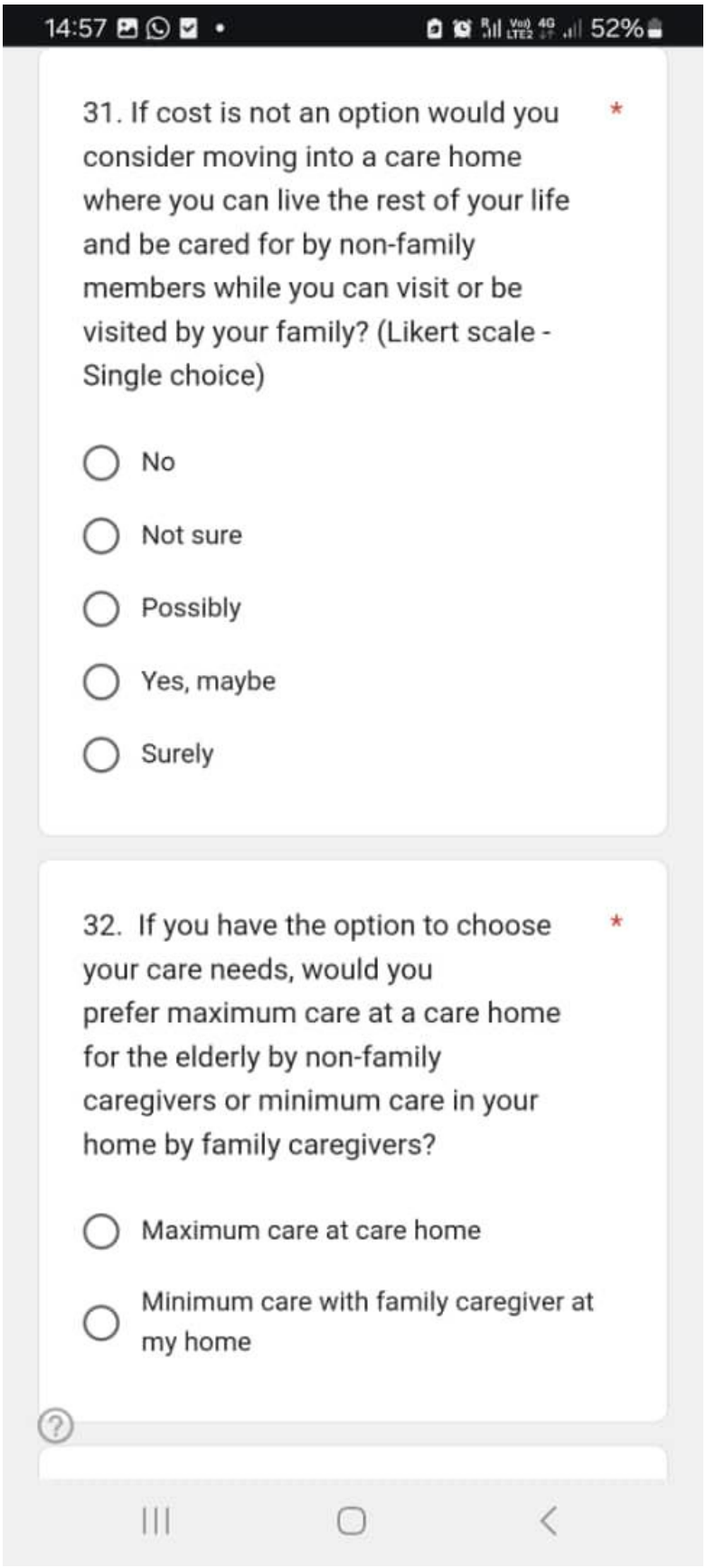
ALTERNATIVE OPPORTUNITY FOR CARE *
29. How open are you to receiving care from non-family members, such as professional caregivers or volunteers? (Single choice)
Not open at all
Reluctant
Neutral
Somewhat open
Very open
30. Are you aware that there are care homes in Nigeria where the elderly can live the rest of their lives and be cared for by non-family members at a fee? *
Yes
No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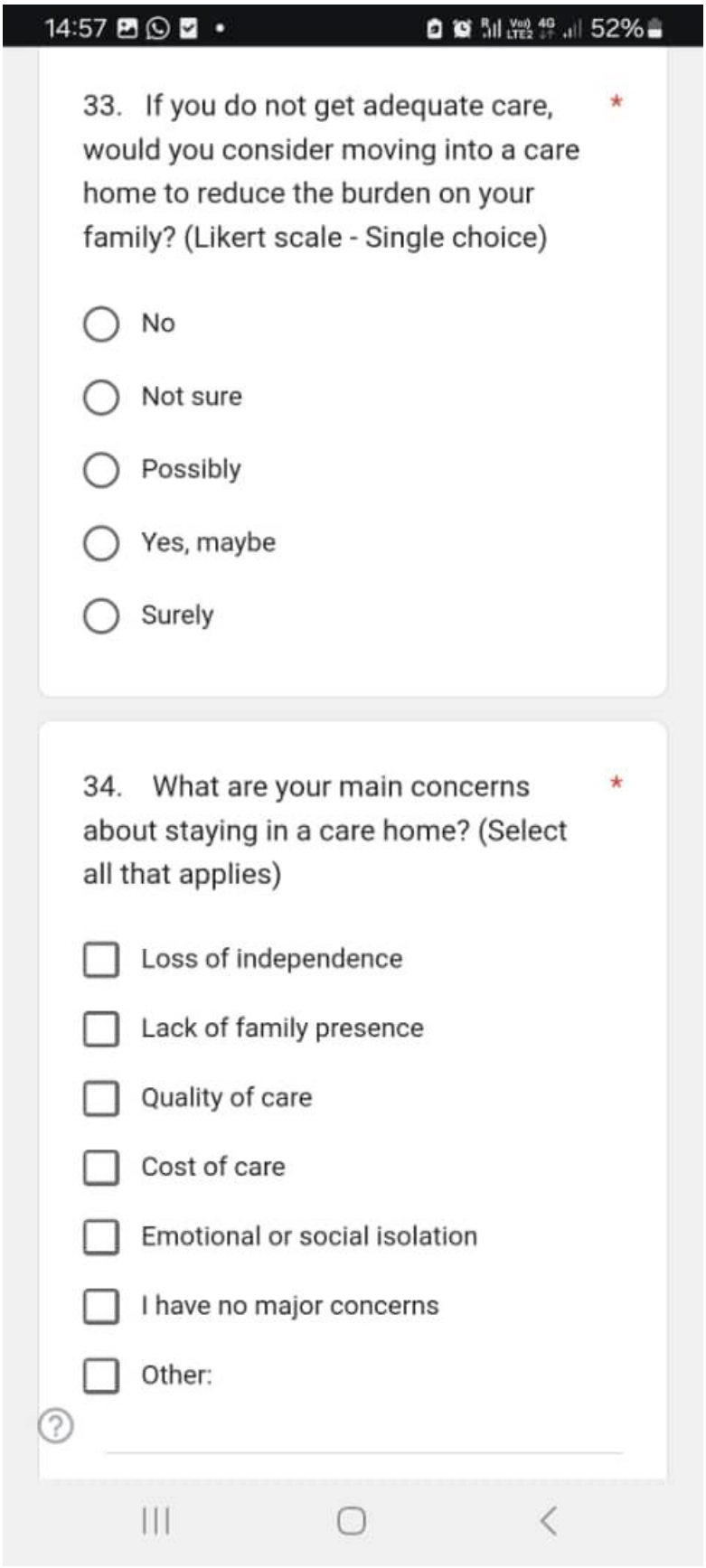
31. If cost is not an option would you consider moving into a care home where you can live the rest of your life and be cared for by non-family members while you can visit or be visited by your family? (Likert scale - Single choice) *
No
Not sure
Possibly
Yes, maybe
Surely
32. If you have the option to choose your care needs, would you prefer maximum care at a care home for the elderly by non-family caregivers or minimum care in your home by family caregivers? *
Maximum care at care home
Minimum care with family caregiver at my home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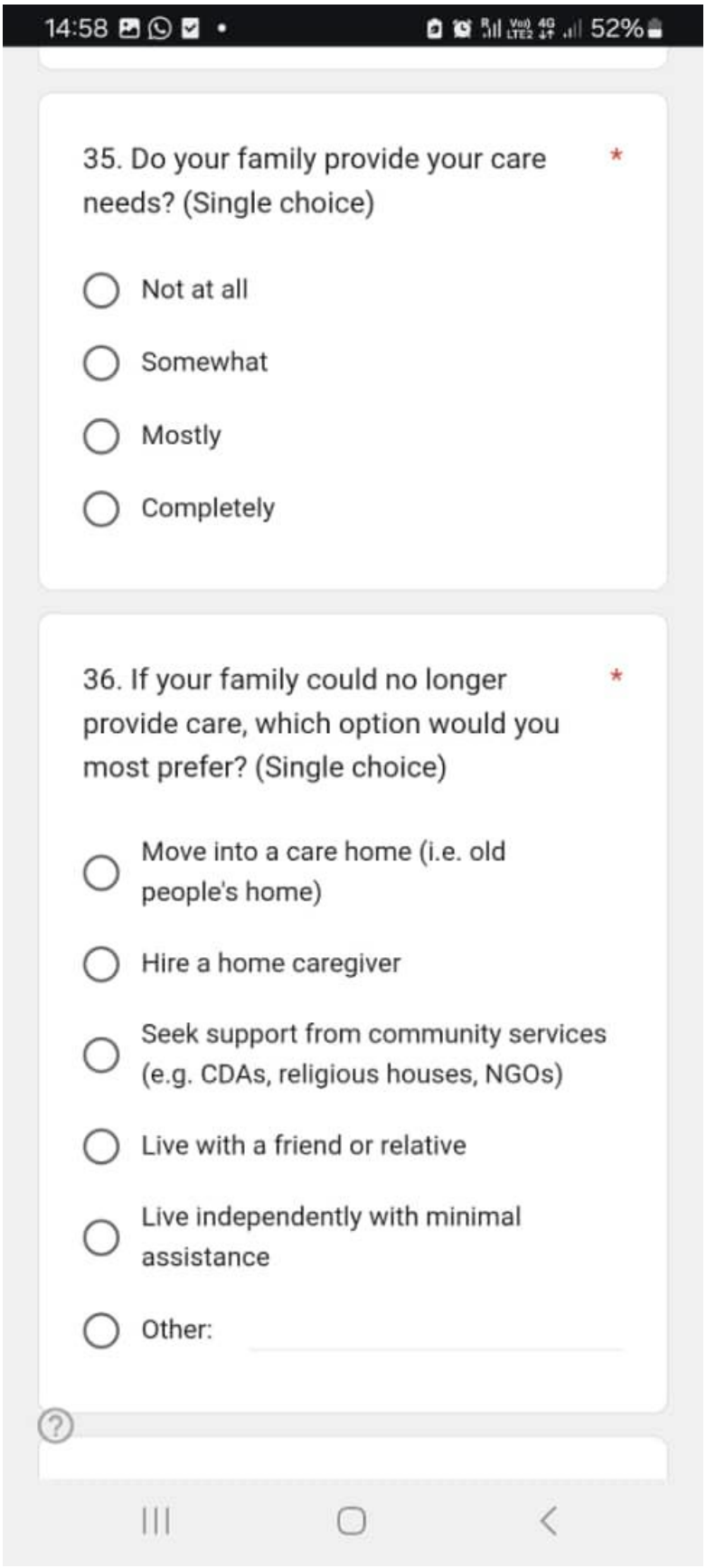
33. If you do not get adequate care, would you consider moving into a care home to reduce the burden on your family? (Likert scale - Single choice) *
No
Not sure
Possibly
Yes, maybe
Surely
34. What are your main concerns about staying in a care home? (Select all that applies) *
Loss of independence
Lack of family presence
Quality of care
Cost of care
Emotional or social isolation
I have no major concerns
Other: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35. Do your family provide your care needs? (Single choice) *
Not at all
Somewhat
Mostly
Completely
36. If your family could no longer provide care, which option would you most prefer? (Single choice) *
Move into a care home (i.e. old people's home)
Hire a home caregiver
Seek support from community services (e.g. CDAs, religious houses, NGOs)
Live with a friend or relative
Live independently with minimal assistance
Other:

37. To what extent do you agree with the following statements that care homes provide better care to the elderly than family based care? (Likert Grid - Answer all) *

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| Family based caregiving strengthens family bonds | ○ | ○ | ○ | ○ | ○ |
| Family based care giving ensures shared obligations and resposibilities | ○ | ○ | ○ | ○ | ○ |
| Care homes promote hygiene | ○ | ○ | ○ | ○ | ○ |
| Care homes ensure social interaction | ○ | ○ | ○ | ○ | ○ |
| Inter-generational conflict is common in family based caregivng | ○ | ○ | ○ | ○ | ○ |
| Family based caregiving leads to family caregiver fatigue | ○ | ○ | ○ | ○ | ○ |
| Placing a loved one in care home is socially shameful | ○ | ○ | ○ | ○ | ○ |
| Placing a loved one in a care home leads to isolation/abandonment | ○ | ○ | ○ | ○ | ○ |

**THE ELDERLY DECISION MAKING** *

38. Do you defer (seek consent/submit to the wishes) to your children in making a decision? (Single choice)

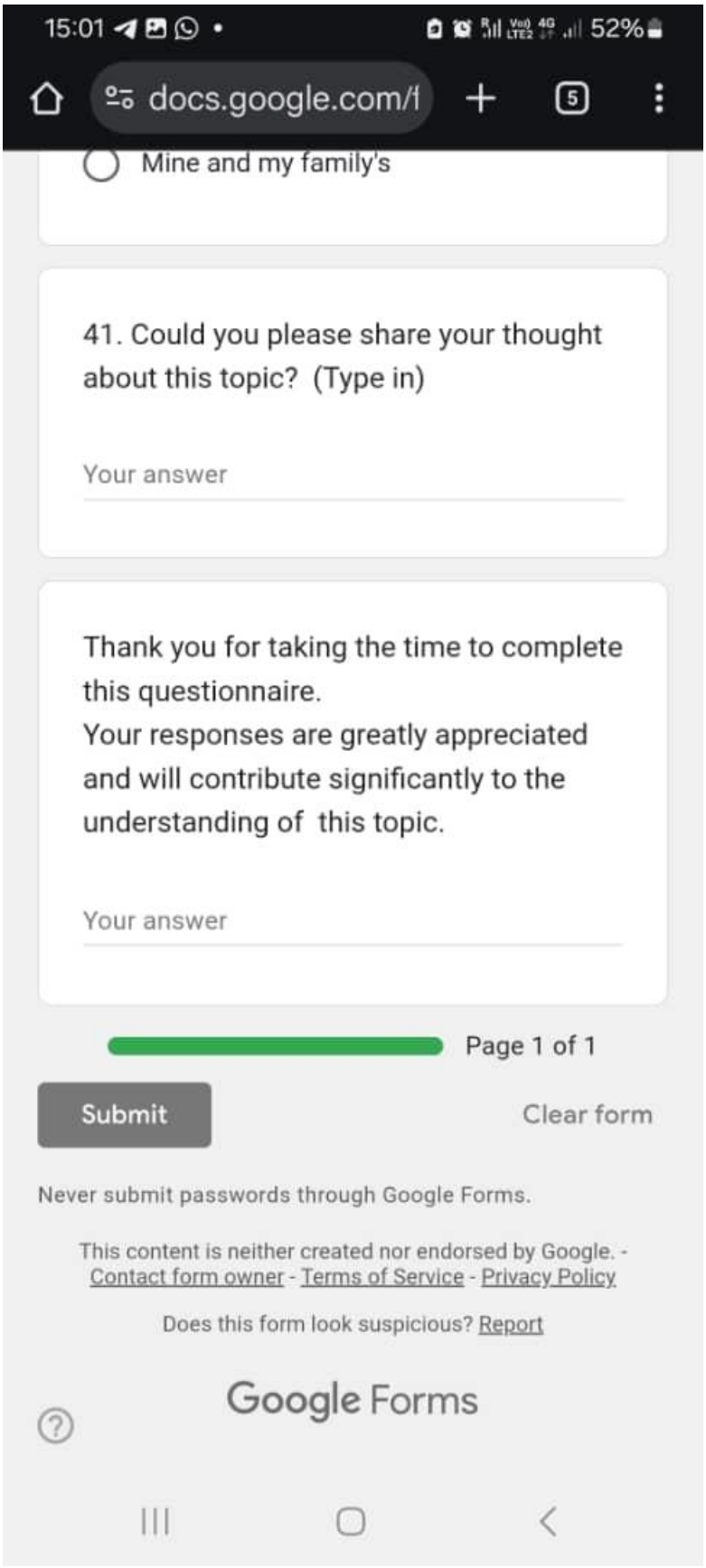
- ◯ Always
- ◯ Most times
- ◯ Sometimes
- ◯ A few times
- ◯ Never

39. Do your children influence your decision? (Single choice) *

- ◯ Always
- ◯ Most times
- ◯ Sometimes
- ◯ A few times
- ◯ Never

40. Whose decision would it be if you were to go to a care home for the elderly? * (Single choice)

- ◯ Mine
- ◯ My Family's
- ◯ Mine and my family's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Mine and my family's
41. Could you please share your thought about this topic? (Type in)
Your answer
Thank you for taking the time to complete this questionnaire.
Your responses are greatly appreciated and will contribute significantly to the understanding of this topic.
Your answer
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