

## **Gender Differences in the Social Engagement and Self-Rated Health of Retirees in a Nigerian Setting**

Eucharia Onyema Ejechi

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**Abstract:** *The social engagement and self-rated health of retirees were studied for gender differences in a Nigerian setting. The study was based on the hypothesis that gender difference in the level of social engagement entailing particularly, the traditional ceremonies may be reflected in differential self-rated health. The engagement (visitations, traditional ceremonies, religious activities and leisure/physical activities) and self-rated health were assessed with structured questionnaire-based scales. Female retirees dominated traditional and religious activities and it contributed to their overall significantly better social engagement ( $P=0.001$ ) than the male retirees. Female retirees also reported better self-rated health (63% vs. 45% in the “good” category). There was a significant association ( $P=0.025$ , chi square) between self-rated health and gender and a positive correlation ( $P=0.05$ ) between self-rated health and social engagement in both sexes. Thus participation in traditional and religious activities by the elderly adults especially among males needs to be encouraged as part of stratagem for promoting healthy ageing.*

**Keywords:** *African ceremonies; Nigeria; Gender; Retirees; Self-rated health; Social engagement.*

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### **I. Introduction**

Ageing is associated with changes in the social, physical and psychological aspects of individuals (Drewnowski & Evans, 2001; Crombie et al. 2004). It affects the ability of the body to adapt to stresses and strains thereby leading to progressive decline in health and increase in the chances of mortality (Levy 2003; Vina et al. 2007). Social engagement is one of the keys to healthy ageing that may promote physical health and cognitive function as many studies have indicated (e.g. Kiely et al. 2000; Fratiglioni et al. 2002; Mendes de Leon et al. 2003; Bennett 2005; Hunter et al. 2011). Social engagement has also been reported to be associated with lower mortality risks (House et al. 1982; Kiely & Flacker 2003). Thus differences in social engagement are likely to influence the course of healthy ageing among elderly women and men. For example Thomas (2011) reported that older women who spent more time in social activities had fewer subsequent cognitive limitations whereas their male counterparts who experienced cognitive limitations were less likely to be as socially engaged.

Custom and cultural activities vary across the world and may also explain differences in types and intensity of social engagement and invariably influence self-rated health and gender differences. The impact of social engagement on the health of elderly people has been well documented in many non-African settings while in contrast only little research has been conducted in Africa particularly in sub-Saharan area. However, two studies from Nigeria and Kenya reported contact with friends and participation in family and community activities by elderly people as the most important factors contributing to the quality of life and self-rated health of the respondents in their sample (Gureje et al., 2008; Kodzi et al. 2010). Contact with friends and community activities may include many traditional and cultural practices that involve celebrations, which indeed are social engagement activities. In Nigeria, marriages, child birth and naming are usually celebrated with relatives and friends with the elders presiding (Chuku, 2008). Burial rites and ceremonies are usually associated with processions and blockage of roads. It is commonly believed that observing burial rites is likely to prevent the ghost of the departed from haunting or harassing the relatives (Chuku, 2008). The beginning of the rainy season and harvest of new yams are marked with funfair festivals associated with a variety of masquerade dances in the traditional Igbo communities of South East Nigeria. These have been depicted in many Nigerian films (Uwah, 2011). Age grade initiations and acquisition of chieftaincy titles are associated with carnivals in Nigeria and Ghana (Adjaye & Misawa, 2006). With respect to religion, God is the almighty that can only be reached through smaller gods and deities that are usually worshiped with pomp and pageantry (Uwah, 2011). All these are traditional social activities in which variations in the levels of male and female participation may be associated with the health of the elderly.

The concept of self-rated health has been well researched in gerontology and geriatrics, because of its use in predicting adverse health and even mortality (Idler & Kasi, 1995; Idler & Benjamin 1997; Ferraro & Kelley-More 2001; Wolinsky et al. 2008). These reports suggest among others that a decline in self-rated health is related to reduction in physical activity and cognitive functioning. The report of Benjamini et al. (2000) also

showed that active functioning among others affect self-rated health. Gender difference in self-rated health has attracted attention of researchers given the knowledge that it is a predictor of adverse health.

It is generally known that women tend to live longer than men, but report worse self-rated health (McDonough & Walters 2001; Idler 2003; McCullough & Laurenceau 2004; Case & Paxson, 2005; Cummings & Jackson 2008). However, there were studies that did not find any significant gender difference in self-rated health (e.g. Cramm & Nieboer, 2011; Demirchyan et al. 2012). Another investigation by Gomez-Olive et al. (2010) showed that while there was gender difference in health status of elderly people (including self-rated health), it did not occur in the overall quality of life. Though not far-reaching as in high income countries, studies reporting gender difference in self-rated health have also been carried out in sub-Saharan countries like Ghana, Tanzania, Kenya and South Africa (Depbuur et al., 2010; Nawi et al., 2010; Mwanyangala, 2010; Kodzi et al. 2010). These Africa-based studies observed poorer self-rated health by women and reported varying associations between self-rated health and socioeconomic levels, age, marital status, living arrangements or education like those in high (Western Europe, USA) and middle (India, Eastern Europe) income countries (e.g. Idler 2003; McCullough & Laurenceau 2004; Case & Paxson, 2005; Helasoja et al. 2006; Cummings & Jackson 2008; Perlman & Bobak, 2008; Gele & Harsløf, 2010; Singh et al. 2013). Another report from Ghana considered the influence of housing type and affordability on self-reported general and mental health status of the respondents without ageing or gender influence (Arku et al., 2011). None considered traditional and cultural social activities as likely associated factors.

In Nigeria, researchers on ageing tended to focus more on the adverse effect of poorly implemented pension scheme on retirees and the quality of life of elderly Nigerians with little attention to gender differences (e.g. Ogunbameru, 1987; Ogunbameru & Bamiwuye, 2004; Eboiyehi, 2006; Gureje, 2007; Fajemilehin & Odebiyi, 2011; Ichoku, et al. 2011; Ejechi, 2012; Alawode & Lawal, 2014). Of the few studies that indicated gender difference, depressive disorder, physical disability and functional limitation and not self-rated health were investigated (Abdulraheem et al, 2011; Gureje et al. 2006; 2007). Women suffered more from these disorders than men as the three reports showed. However the report by Akinyemi & Aransiola (2010) on self assessment of the quality of life of the elderly in South West Nigeria, found women reporting better quality of life than the men in the domain of Activities of Daily Living (ADL) while the men reported better health in the psychosocial, somatic and sexual domains. This inconsistency and the limited gender based assessment underscores the need for further investigation of gender difference in self-rated health among elderly Nigerians.

Most studies on social activities of elderly people tend to focus on engagements such as tourism, indoor sports, reading newspaper, watching television, jogging relaxation on beaches, exchange of visits, political party participation, and volunteer services e.t.c. (e.g. Kiely et al. 2000; Bennet, 2002; 2005; ELSA, 2002; Wang et al. 2002; Rodriguez-Galan & Falcon, 2010). Unique traditional and cultural social activities like those in Nigeria are yet to be fully considered in ageing and quality of life studies as likely contributors to health even by researchers of ageing in Nigeria (e.g. Fajemilehin and Odebiyi, 2011; Gureje et al. 2006; 2008; Adebowale et al. 2012). These Nigerian social activities may be gendered, because it is known that history and culture influence gender roles within the norms of the society (Holmes, 2009). The knowledge of gendered activities is important, because it can provide the basis for policies that target the health needs of both sexes (Doyal, 2001). Thus the paucity of information in the Nigerian setting necessitated an investigation aimed at ascertaining the gender differences in social engagement and self-rated health and their relationship in a Nigerian setting.

## **II. Method**

### **Data source**

The data for the study were obtained from retirees with structured questionnaires consisting of four social engagement domains: visitations, traditional ceremonies, religion, and leisure/physical activities (Table 1) and a one-item scale for self-rated health. The activity units (Table 1) of the domains of visitations and leisure/physical activities were obtained from validated scales routinely used in gerontology research (e.g. ELSA, 2002; Menec, 2003). Although traditional ceremonies and religious worships are of common knowledge in Nigeria the activity units (Table 1) were derived from focused group discussions where participants identified the different types of traditional and cultural ceremonies, and religious worship styles. A group of eight made up of two persons (male and female) aged between 60 and 65 years randomly selected from each of the four ethnic groups (Igbo, Ijaw, Itsekiri and Urhobo) in the study area (Delta State, Nigeria) explored the two domains. Thereafter a Likert scale was developed for the two domains, tested and retested in pilot studies with 50 randomly selected retirees' participants. A reliability test with SPSS version 20 gave a Cronbach's alpha of 0.68.

**Table 1:** Description of social engagement activities

The engagement domains/units measured			
<sup>a</sup> Visitation	<sup>b</sup> Traditional ceremonies	<sup>c</sup> Religion	<sup>d</sup> Leisure/Physical activities
From children	Marriages	Worship services	Volunteer work
To children	Funerals	Church programmes	Farming
From extended family	Conferment of titles	Evangelism	Gardening
To extended family	Community festivals	Church societies	Walking
From friends	Child naming ceremony	Traditional worship	Indoor sports
To friends	Age grade initiation		Travelling
			Reading
			Writing
			Watching TV
			Grand parenting
			Trading
			Market trips

Maximum points: <sup>a</sup>30; <sup>b</sup>30; <sup>c</sup>25; <sup>d</sup>60.

The questionnaire was administered by trained assistants in the home of respondents at one per home (male or female) in order to remove the potential of spousal influence while answering the questions. Those with poor vision, needed interpretation or those who prefer just to answer questions were assisted to complete the questionnaire. Other respondents simply told the assistants to return at a later date to collect the questionnaires or volunteered to return it by post. The study protocol was approved by the Department of Sociology and Psychology Board for Post-Graduate Studies made up of academic staff not below the rank of Senior lecturers. The Board stands in to advise on ethical issues in the absence of a central Institutional Research Board in the University. Oral permission was obtained from the retiree respondents by the research assistants before the questionnaires were administered. Many respondents here do not want to be identified by any written statement, but would willingly participate on the basis of anonymity. Verbal consents have been used in some studies in Nigeria (e.g. Gureje et al. 2006; 2007; Famileyin & Odebiyi, 2011).

The respondents considered eligible were those that have been in retirement for five years and above, because of the likely manifestation of the effect of inactivity or delayed payment of gratuity and pension on the quality of life of many retirees in Nigeria as has been reported (Eboiyehi, 2006). Based on this, a lower age limit of 65 years was set by adopting Nigeria’s public service mandatory retirement age of 60 years as average age for retirement. A snowball sampling technique was adopted, because of the difficulties in locating retirees and absence of reliable records. The respondents were drawn from the four major towns (Asaba, Agbor, Sapele and Warri) of Delta State, Nigeria where many retirees are likely to be found, because retirees from paid jobs rarely retire to their villages (Ogunbameru, 1987). Of the 600 questionnaires sent out at 150/town, only 360 were returned either by the respondents, the research assistants or by mail. This was due to difficulties associated with getting the permission of the retirees to participate in the study. Some retirees were angry at the delay or non-payment of pension money and refused to cooperate while others claimed they have been visited by people seeking one information or the other and that nothing came out of it. Assurances were given to participants that the study was being undertaken by University lecturers for knowledge and training of their children and not for Government or their agents whom they do not trust. The socio-demographic variables in the sample include age, gender, living with or without spouse, educational level attained and annual pension income.

**Measures**

The activity units in each of the domains (Table 1) were measured with Likert scales. With regards to the visitation domain, respondents were asked to respond to the question “How often do your children, friends or extended family members visit you and how often do you visit them? Answers were given on a five-point scale (never, 1; not often, 2; often, 3; very often, 4; always, 5). For the other domains/activity units (Table 1), the same five-point scale was used, but with the questions modified as follows: “How often do you attend, participate or are involved in the following traditional ceremonies and religious and physical/leisure activities”? The self-rated health was measured with the traditional routinely used scale: “In general would you say your health is excellent, 5; very good, 4; good, 3; fair, 2 or poor, 1?”

**Data analyses**

Since the data was generated through non-probability sampling, mode/range was used to describe the central tendency on the basis of the categories while the gender differences were tested with Mann-Whitney U test. Graphs were used to illustrate the variation in the scores (mode) of the engagement units in each of the domains (Table 1). However, for the purpose of analyses on the basis of the socio-demographic variables, the scores from each of the four domains of engagement (Table 1) were combined and analysed with descriptive statistics and Mann-Whitney U test for gender differences. Each of the domains were also analysed for gender difference by Mann-Whitney U test. The total score for each domain was calculated by multiplying the points scored for each activity unit with the number of units under each domain (Table 1). Since it was based on a scale of 5, each unit would have a maximum of 5 points. Given the limited sample size due to low response rate and difficulties in locating retirees, the “excellent” “very good” and “good” measures of the self-rated health scale were combined as “Good”. The numbers of respondents that rated their health as “Good”, “Fair”, or “Poor” were computed as percentages of the sample population. Thereafter, chi square analyses were performed to test the influence of gender and other socio-demographic variables on self-rated health. The association between social engagement and self-rated health was tested with Spearman correlation statistics.

**III. Results**

The socio-demographic characteristics are presented in Table 2. The female retirees were less than 50% of the sample while the number of respondents decreased with age. However, slightly more than half (53%) of the sample size were within ages 65-69 years. The median age was central in the age group 65-69, but closer to the lower limit in the other two age categories (Table 2). The table also shows that those living with their spouses were more in the sample while the higher income group and those with tertiary education qualification were fewer. Statistical analyses showed that social engagement was significantly higher with the female retirees than their male counterparts except in the area of leisure/physical activities where no significant difference occurred (Table 3).

**Table 2:** Socio-demographic characteristics of retirees (N=360)

Variable	Male		Female	
	n=200	%	n=160	%
<b>Age</b>				
65-69 (67)	106	53.0	74	46.2
70-74 (71)	73	36.5	59	36.9
75+ (76)	21	10.5	27	16.9
<b>Living:</b>				
With spouse	144	72.0	86	53.8
Without spouse	56	28.0	74	46.2
<b>Education</b>				
≤Secondary	105	52.5	112	56.0
Tertiary	95	47.5	48	44.0
<b>*Annual pension income</b>				
≤N120, 000.00	111	55.5	104	65.0
>N120, 000.00	89	44.5	56	35.0

Median age in parenthesis; \*Exchange rate: \$1.00=N158.00-N160.00; N, Nigerian currency naira.

**Table 3:** The level of social engagement of retirees and gender difference

Social engagement variables	Mode (range)		*Significant difference (P)
	Male	Female	
Visitation <sup>a</sup>	17(4)	23(3)	0.023
Traditional ceremonies <sup>b</sup>	16(3)	24(3)	0.018
Religious activities <sup>c</sup>	9(4)	21(2)	0.001
Leisure/Physical activities <sup>d</sup>	32(5)	35(4)	0.054
All variables <sup>e</sup>	76 (6)	105(5)	0.001

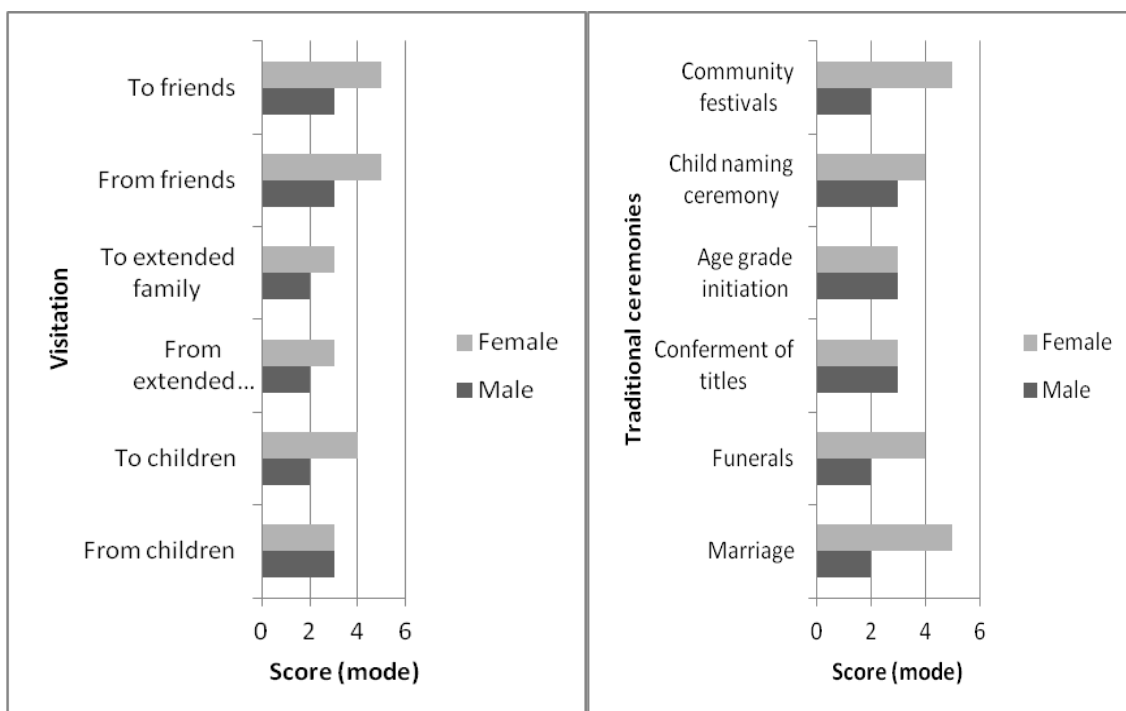
\*Mann-Whitney U tests. Maximum points: <sup>a</sup>30; <sup>b</sup>30; <sup>c</sup>25; <sup>d</sup>60; <sup>e</sup>145. The parentheses contain range values.

Further analyses by graph (Figure 1) revealed that female retirees tended to be more active in all religion domain activity units or variables with a similar trend repeated in visitations except those involving children, which were the same level for both sexes. With respect to participation in traditional ceremonies, Figure 1 also showed that the female retirees still dominated with markedly higher modes in all, but age grade initiations and conferment of chieftaincy titles that the level of participation was the same. There were differences in the level of engagement in all religion domain activity units or variables with a tendency to higher participation by female retirees' respondents (Figure 1). However, the engagement in physical/leisure activities did not follow the above trends. The female dominant trend became reduced with higher modes only in 5 of the 12 units of activity variables while men surpassed in 4 (Figure 1). They were at the same level with the male retirees in 3 variables of the leisure/physical activities (Figure 1).

The social engagement activities were also analysed on the basis of the socio-demographic variables taking all the engagement variables (activities) together as one. The analyses revealed that the social engagement of female retirees were generally significantly higher in all the socio-demographic variables except for those above 69 years where no significant difference was observed (Table 4).

The socio-demographic variables notwithstanding, the respondents tended to report good health with 42-65% in the "good" category (Table 5). Chi square analyses of the self-rated health of retirees indicated significant association with gender with the female respondents reporting better health (Table 5). Ageing, living with/without spouse and pension income were significantly associated with self-rated health while educational level was not (Table 5).

The Spearman correlation analyses indicated significant positive relationships between all the categories of social engagement and self-rated health in respect of the female retirees whereas it occurred in only one category (leisure/physical activities) with the males (Table 6). However, significant positive relationship occurred in both sexes when all the engagement activities were combined (Table 6).



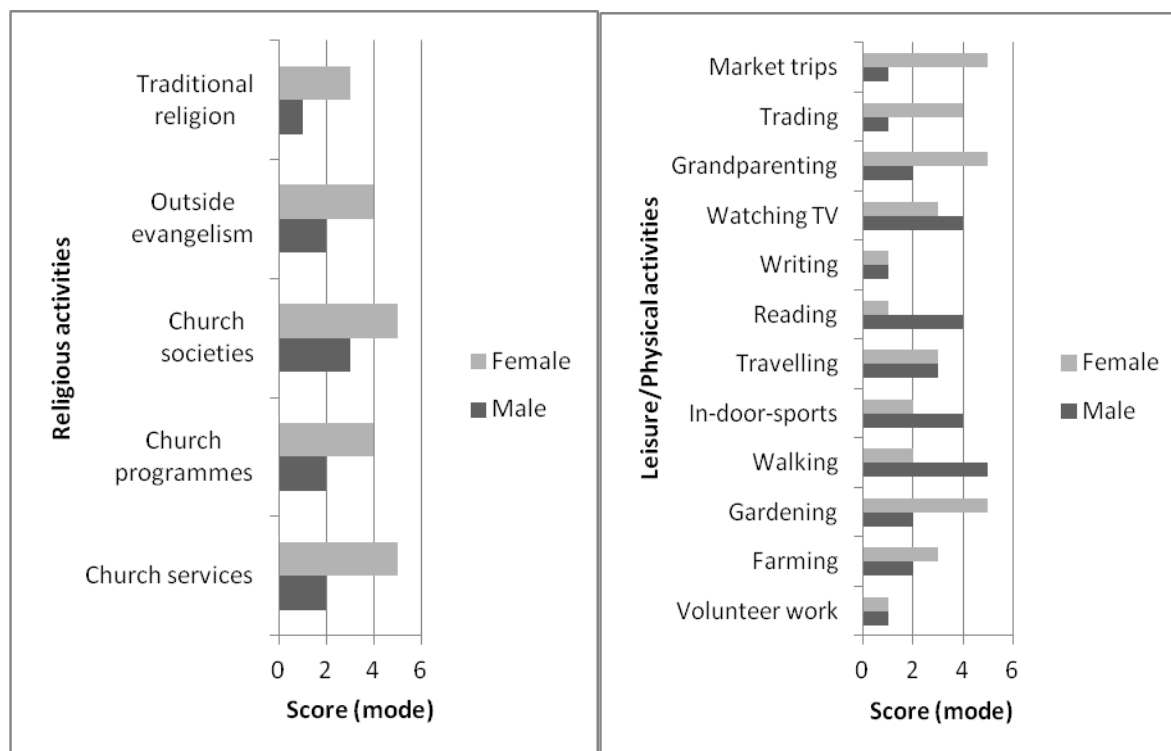


Figure 1: Trends in the modes of activity variables within the four social engagement groups.

Table 4: Gender differences in the overall social engagement on the basis of socio-demographic variables

Variables	Social engagement score (mode)		*Significant difference (P)
	Male	Female	
<b>Age</b>			
65-69	79(6)	110(6)	0.009
70-74	64(7)	68(5)	0.108
75+	45(5)	51(4)	0.120
<b>Living</b>			
With spouse	75(5)	106(6)	0.005
Without spouse	76(6)	110(7)	0.004
<b>Education</b>			
≤Secondary	69(6)	97(7)	0.006
Tertiary	75(5)	108(7)	0.005
<b>Annual pension income**</b>			
≤N120, 000.00	72(7)	105(6)	0.005
>N120, 000.00	75(6)	108(7)	0.005

\*Mann-Whitney U tests. The parentheses contain range values. \*\*Exchange rate: \$1.00=N158.00-N160.00; N, Nigerian currency naira.

Table 5: Self-rated health (SRH) of retirees

Variables	Respondents [n (%)]			X <sup>2</sup> (P)
	SRH: Good	Fair	Poor	
<b>Gender</b>				
Male	90(45)	70(35)	40(20)	11.96(0.003)
Female	100(63)	43(27)	17(11)	
<b>Age</b>				
65-69	117(65)	45(25)	18(10)	37.14(0.000)

70-74	51(39)	62(47)	19(14)	
75+	15(31)	18(38)	15(31)	
<b>Living:</b>				
With spouse	133(58)	76(33)	21(9)	20.86(0.000)
Without spouse	55(42)	40(31)	35(27)	
<b>Education</b>				
≤ Secondary	119(55)	65(30)	33(15)	0.37(0.832)
Tertiary	80(56)	39(27)	24(17)	
<b>Annual pension*</b>				
≤N120.000.00	98(45)	66(31)	51(24)	13.21(0.001)
>N120.000.00	83(57)	49(34)	13(9)	

\*Exchange rate: \$1.00=N158.00-N160.00; N, Nigerian currency naira.

**Table 6:** The Association between social engagement and self-rated health

Social engagement	Spearman correlation coefficient (rs)	
	Male	Female
Visits	0.30	0.38*
Ceremonies	0.27	0.39*
Religion	0.22	0.40*
Leisure/Physical	0.37*	0.36*
Overall	0.33*	0.42*

\*P<0.05

#### IV. Discussion

The literature is replete with studies indicating the positive association of social activities with ageing (e.g. Kiely et al. 2000; Fratiglioni et al. 2002; Mendes de Leon et al. 2003; Bennett, 2005; Hunter et al 2011). One of the objectives of the study was to ascertain the gender differences in participation and level of engagement in social activities by retirees with particular attention to the aspect concerning Nigeria's culture and tradition. The findings here indicated greater social engagement by female retirees especially in religious activities. The finding that more female retirees participated in religious activities than the males is consistent with the findings of some investigations conducted in America, the United Kingdom and China (Idler & Kasl, 1997; Chatters et al. 1999; Zhang, 2010; Lewis et al. 2011). On the other hand participation in mosque services in South East Europe, Asia, North Africa Middle East and sub-Saharan Africa was dominated by men (Anon, 2012) suggesting that religious activity and gender may be culture or environment dependent. An evidence for this observation came from the report by Loewenthal (2001) where non-Christian (Hindu, Jewish and Muslims) women indicated lesser religious activity than the men.

Apart from religious activities, female retirees were also more involved in visitations than their male counterparts. It is common knowledge that the cultural role of women in caring for children gives them the advantage of regular visits to assist with the care of grandchildren especially when their daughters are career women. In addition cultural practices like "omugwo" (caring for mother and new-born babies) in Igbo speaking area of Nigeria give elderly women more visiting opportunities than their male counterparts.

The frequency of participation in some traditional ceremonies such as marriages, child naming ceremonies, community festivals and burials tended to be higher with female retirees. These activities especially the burial of aged persons are usually celebrated in many parts of Africa including Nigeria with singing, dancing and masquerade appearances (Mbiti 1990). The singing, dancing and entertainment of participants and visitors, which are usually female-dominated and led by elderly women (Okehia-Offoha & Sadiku (1996) suggests greater level of involvement by women. The non-dominance of age grade initiations and acquisition/conferment of chieftaincy titles may be associated with the masculinity of the rituals and the masquerade dances involved. Chieftaincy title holders are those chosen to be custodians of the community's tradition and customs and such titles are conferred by the king if it is a monarchical structure of administration or by the elders if it is gerontocracy (Adjaye & Misawa, 2006). Some titles may be hereditary or by the attainment of a specific age (Adjaye & Misawa, 2006). Masquerades are seen as spirits in human form that can convey blessings of fertility, herald farming seasons, mark bountiful harvests, invoke the wrath of the gods, pronounce disciplinary penalties or confirm the acceptability of the gods in award of chieftaincy titles and ritualistic initiations (Enendu, 2014).

The different masks used by the masquerades represent different spirits (Enendu, 2014). Ceremonies marking transition of boys to adulthood otherwise known as age grade initiations, involve physical fitness rituals calculated to toughen the boys in order to prepare them for adulthood (Njoh, 2006). Events that utilize masquerades form part of the African culture and women do not participate (Ododo, 2001; O'Toole 2006). By this it would have been expected that participation of women in age grade initiations and chieftaincy rituals would be markedly lower than that of the men, rather they tended to be at the same level. This may be attributed to the fact that women are only excluded from the associated rituals, but allowed to take part in the festivities that follow. The age grade initiation for the transition of girls into womanhood through rituals involving circumcision (removal of female clitoris) is no longer a popular practice because of the risk of infection and the campaign against by feminists (Abiodun et al. 2011).

Based on the findings, significant gender differences in the area of leisure and physical activities did not occur. Unlike some traditional activities, watching television, reading newspapers, travelling for leisure, reading, writing and indoor sports are activities associated with education and technology that are not gendered. Education did not adversely affect participation in some of these traditional activities, because of the need to preserve cultural identity in the post-colonial era. The absence of gender difference in the leisure/physical activities domain in this report is consistent with the observation of McGinnis (2003) that gender significations are less limiting in sports and leisure among others, in post modern era than they were in the past. Generally, the gender differences in the social engagement activities tended to disappear with ageing thereby suggesting the onset of physical disabilities such as poor vision and arthritis that may limit movement in both sexes.

There were more respondents in the good category of self-rated health than fair or poor with the women tending to report better health. This is in contrast with reports from some high income countries that men tended to rate their health better than women (e.g. McDonough & Walters 2001; McCullough & Laurenceau 2004; Cummings & Jackson 2008; Molarius et al., 2012). Some studies on self-rated health of elderly adults from some sub-Saharan African countries (Ghana, Kenya, Tanzania and Kenya) also showed that women reported poorer health than men ((Depbuur et al., 2010; Nawi et al., 2010; Kodzi et al. 2010; Kyobutungi et al. 2010; Mwanyangala 2010). The reports from the high income countries were general and not specific for old age while those cited from sub-Saharan Africa were based on samples of elderly adults with diverse background and not retirees from pensionable jobs. Thus the higher self-rated health of the female retirees in this report may not be out of place. Besides, there are occasional reports where women report better health than men (Idler, 2003) or where no significant gender difference was found (Cramm & Nieboer, 2011; Demirchyan et al. 2012). The few ageing studies in Nigeria that reported gender difference were on depressive disorder, physical disability and functional limitation and not self-rated health per se (Abdulraheem et al, 2011; Gureje et al. 2006; 2007).

An association between self-rated health and living with/without spouse or pension income was observed. Unlike in widowhood, spousal presence ensures companionship that will not bring loneliness at old age (Utz et al. 2002). Income that is sufficient to meet daily needs is likely to bring happiness that can also influence self-rated health (e.g. Depbuur et al. 2010). The positive relationship between all the social engagement domains and the self-rated health observed with female retirees provides evidence for their higher health rating. Although significant relationship with the self-rated health of the male retiree respondents were observed when all the social activity variables were combined, the correlation coefficient was markedly lower than that of the female retirees.

One of the limitations of this study is that it focused on retirees from pensionable jobs whereas there are self-employed elders that may have retired and left their private businesses for their children. For example, compared to men, the female respondents were lesser in number and this may be due to the non-inclusion of retirees from the distribution and retail businesses that are mostly personal and dominated by women. Another limitation was the sample size and the non-probability approach due to difficulties in locating and getting the cooperation of the retirees. All these make it difficult to generalise conclusions especially on the observed self-rated health of female retirees that was inconsistent with many reports in the literature. There is the likelihood of variables such as ethnicity, religious denominations and previous employment of retirees indicating some differences. However, these variables were not considered because of the sample size. This limitation has been addressed in an on-going cross-sectional survey with a larger population sample of elderly adults that is not limited to retirees from paid jobs.

## **V. Conclusion**

The study revealed gender differences in both social activities and self-rated health and suggests that visitation, traditional and religious activities dominated by women may have been contributory factors. This observation is supported by the positive correlation between visitation, participation in religious activities or traditional ceremonies and self-rated health, which was not encountered with the males. This study suggests that the aspect of traditional ceremonies in sub-Saharan Africa hitherto ignored need to be further investigated as likely one of the multifaceted determinants of good health that can be promoted by encouraging participation.



The gender difference suggests that adult males should be the main target of the promotion especially for those that relocate to the rural areas after retirement. The singing and dancing in religious and other traditional ceremonies in sub-Saharan Africa (Mbiti, 1990) may promote good health for the elderly, because they can be physically exerting. This hypothesis is the subject of another investigation, because physical activity can promote healthy ageing (Byberg et al, 2009; Ejechi, 2013).

## References

- [1]. Abdulraheem, I. S., Oladipo, A. R. & Amodu, M. O. (2011). Prevalence and Correlates of Physical Disability and Functional Limitation among Elderly Rural Population in Nigeria. *Journal of Aging Research*, Article ID369894, 13pages. doi:10.4061/2011/369894
- [2]. Abiodun, A. A., Oyejola, B. A. & Job, O. (2011). Female Circumcision in Nigeria, Prevalence and Attitudes. *Centrepoint Journal (Science edition) 17(2): 89 – 98*.<http://www.unilorin.edu.ng/centrepoint>
- [3]. abowale, S. A., Atte, O. & Ayeni. O. (2012). Elderly Well-being in a Rural Community in North Central Nigeria, sub-Saharan Africa. *Public Health Research, 2(4): 92-101* DOI: 10.5923/j.phr.20120204.05
- [4]. Adjaye, J. K., & Misawa, B. (2006). Chieftaincy at the confluence of tradition and modernity: Transforming African rulership in Ghana and Nigeria. *International Third World Studies Journal and Review, 27, 1-10*. Retrieved from <http://www.unomaha.edu/itwsjr/ThirdXVII/AdjayeMisawa.pdf>.
- [5]. Akinyemi, A. & Aransiola, J. (2010). Gender perspectives in self-assessment of quality of life of the elderly in South-Western Nigeria. Are there variations in quality of life among ageing men and women? *Journal of Comparative Research in Anthropology and Sociology, 1(1): 107-120*. <http://compaso.ro>
- [6]. Alawode, O. O. & Lawal, O. M. (2014). Income inequality and self rated health in rural Nigeria. *Peak Journal of Agricultural Science, 2 (3): 36-50*. [www.peakjournals.org/sub-journals-PJAS.html](http://www.peakjournals.org/sub-journals-PJAS.html)
- [7]. Anon (2012). The world's muslims: Religious commitment. Pew Research Centre, Washington, D. C. Arku, G. Luginaah, I., Mkandawire, P., Baiden, P. & Asiedu, A. B. (2011). Housing and health in three contrasting neighbourhoods in Accra, Ghana. *Social Science & Medicine, 72(11): 1864-187*
- [8]. Benjamini, Y., E. Idler, E. L., Leventhal, H. & Leventhal, E.A. (2000). Positive effect and function as influences on self-assessments of health: Expanding our view beyond illness and disability. *Gerontology, Series B, Psychological Sciences and Social Sciences SS (2): P107-P116*.
- [9]. Benjamini, Y., Blumstein, T., Lusky, A. & Modan, B. (2003). Gender differences in Self-rated Health-Mortality Association: Is it poor self-rated health that predicts mortality or excellent self-rated health that predicts survival? *The Gerontologist 43(3): 396-405*.
- [10]. Bennett, K. M. (2005). Social engagement as a longitudinal predictor of objective and subjective health. *European Journal of Ageing 2: 48-55*.
- [11]. Bennet, K. M. (2002). Low level social engagement as a precursor of mortality among people in later life. *Age and Ageing, 31: 165-168*.
- [12]. Byberg, L., Melhus, H., Gedeberg, R., Sundstro, M. J., Ahlbom, A., Zethelius, B., Berglund, L. J., Wolk, A. & Michaelson, K. (2009). Total mortality after changes in leisure time physical activity in 50 years old men: 35 year follow-up of population based cohort. *British Journal of Sports Medicine, 43: 482-492*.
- [13]. Case, A. & Paxson, C. (2005). Sex differences in morbidity and mortality. *Demography, 42: 189-214*.
- [14]. Chatters, L. M., Taylor, R. J., & Lincoln, K. D. (1999). African American religious participation: A multi-sample comparison. *Journal for the Scientific Study of Religion, 132-145*.
- [15]. Chuku, C. D. (2008). Rite of passage as agents of socialisation. In B. Okaba (Ed.), *Cultures and peoples of Nigeria* (pp. 125-137). Yenagoa, Nigeria: Ceecia Prints and Publications.
- [16]. Cramm, J. M. & Nieboer, A. P. (2011). The influence of social capital and socio-economic conditions on self-rated health among residents of an economically and health-deprived South African township. *International Journal for Equity in Health, 10(51): 1-7*. <http://www.equityhealthj.com/content/10/1/51>
- [17]. Crombie, I. K., Irvine, L., Williams, B., McGinnis, A. R., Slane, P. W., Alder, E. M. & Mcmurdo, M. E. T. (2004). Why older people do not participate in leisure time physical activity: a survey of activity levels, beliefs and deterrents. *Age and Ageing, 33: 287-29*.
- [18]. Cummings, J. L. & Jackson. P. B. (2008). Race, Gender, and SES Disparities in Self-Assessed Health, 1974-2004. *Research on Aging 30: 137-167*.
- [19]. De Kloet, E. R., Joels, M. & Holsboer. F. (2005). Stress and the brain: from adaptation to disease. *National Neuroscience, 6: 463-75*.
- [20]. Debpuur, C., Welaga, P. Wak, W. & Hodgson, A. (2010). Self-reported health and functional limitations among older people in the Kassena-Nankana District, Ghana. *Global Health Action Supplement 2*, pp 54-63. DOI: 10.3402/gha.v3i0.2151.
- [21]. Demirchyan, A. Petrosyan, V. & Thomson, M. E. (2012). Gender differences in predictors of self-rated health in Armenia: a population-based study of an economy in transition. *International Journal for Equity in Health, 11:67*<http://www.equityhealthj.com/content/11/1/67>
- [22]. Doyal, L. (2001). Sex, gender, and health: the need for a new approach. *BMJ, 323:1061-3*
- [23]. Drenowski, A. & Evans, W. J. (2001). Nutrition, Physical Activity, and Quality of Life in Older Adults: Summary. *Journals of Gerontology Series A, 56(2): 89-94*. doi:10.1093/gerona/56.suppl\_2.89
- [24]. Eboiyehi, F. A. (2006). Life in retirement: A qualitative study of pensioners in Ibadan. *Ife Psychologia, 14(2), 245-262*.
- [25]. Ejechi E. O. (2012). The quality of life of retired reengaged academics in Nigeria. *Educational Gerontology, 38: 328-337*.
- [26]. Ejechi, E. O. (2013). A comparative study of physical activity and cognitive function of a sample of elderly Nigerians living in a rural and an urban area. *International Journal of Humanities and Social Science, 3(6): 140-150*.
- [27]. ELSA (2002). Health and lifestyles of people aged 50 and over: Self-completion questionnaire in confidence. English longitudinal study of ageing (ELSA), Institute for Fiscal Studies London. Retrieved from <http://www.elsa-project.ac.uk/documentation>.
- [28]. Enendu, M. L. O. (2014). African masquerade: The essence, the performance and the institution. *Peak Journal of Social Sciences and Humanities, 2 (2): 9-13*. <https://www.peakjournals.org/sub-journals-PJSSH.html>
- [29]. Fajemilehin B. R. & Odebiyi, A. (2011). Predictors of elderly persons' quality of life and health practices in Nigeria. *International Journal of Sociology and Anthropology 3(7): 245-252*. Retrieved from <http://www.academicjournals.org/IJSA>

- [30]. Ferraro, K. F. & Kelley-Moore, J. A. (2001). Self-rated health and Mortality among Black and White adults: examining the dynamic evaluation thesis. *Journals of Gerontology, Series B, Psychological Sciences and Social Sciences*, 56 (4): S195-S205.
- [31]. Fratiglioni, L., Wang, H. X., Ericsson, K., Maytan, M. & Winblad, B. (2000). Influence of social network on occurrence of dementia: A community-based longitudinal study. *Lancet*, 355: 1315–1319.
- [32]. Gele, A. A. & Harsløf, I. (2010). Types of social capital resources and self-rated health among the Norwegian adult population. *International Journal for Equity in Health*, 9(8): 1-9. <http://www.equityhealthj.com/content/9/1/8>.
- [33]. Gomez-Olive, F. X., Thorogood, M., Clark, B. D., Kahn, K. & Tollman, S. M. (2010). Assessing health and well-being among older people in rural South Africa. *Global Health Action Supplement 2*: 23-35. DOI: 10.3402/gha.v3i0.2126.
- [34]. Gureje, O., Kola L. & Afolabi, E. (2006). Functional disability among elderly Nigerians: results from the Ibadan Study of Ageing. *Journal of American Geriatric Society*, 54(11): 1784–1789. doi:10.1111/j.1532-5415.2006.00944.x.
- [35]. Gureje, O., Kola, L. & Afolabi, E. (2007). Epidemiology of major depressive disorder in elderly Nigerians in the Ibadan Study of Ageing: a community-based survey. *Lancet* 370: 957–6 370
- [36]. Gureje, O., Kola, L. Afolabi, E. & Olley, B. O. (2008). Determinants of quality of life of elderly Nigerians: results from the Ibadan Study of Ageing *African Journal of Medicine and Medical Sciences* 37(3): 239–247.
- [37]. Helasoja, V., Lahelma, E., Prättälä, R., Kasmel, A., Klumbiene, J. & Pudule I. (2006). The a sociodemographic patterning of health in Estonia, Latvia, Lithuania and Finland. *European Journal of Public Health*, 16(1):8–20.
- [38]. Holmes, M. (2009). *Gender and everyday life*. New York, NY: Routledge.
- [39]. House, J., Robbins, C & Metzner, H. (1982). The association of social relationships and activities with mortality: Prospective evidence from the Tecumseh Community Health Study. *American Journal of Epidemiology*, 116:123-40.
- [40]. Hunter, R. H., Sykes, K., Lowman, S. G., Duncan, R., Satariano, W. A. & Belza, B. (2011). Environmental and Policy Change to Support Healthy Aging. *Journal of Aging & Social Policy*, 23: 354–371.
- [41]. Ichoku, H. E., Fonta, W. M. & Thiede, M. (2011). Socioeconomic gradients in self-rated health: a developing country case study of Enugu State, Nigeria. *Economic Change and Restructuring* 44:179–202. DOI 10.1007/s10644-010-9098-0
- [42]. Idler, E. L. (2003). Discussion: Gender differences in self-rated health, in mortality, and in the relationship between the two. *The Gerontologist*, 43: 372-375.
- [43]. Idler, E. L. & Benjamini, Y (1997). Self-rated health and mortality: a review of twenty-seven community studies. *Journal of Health and Social behaviour*, 38 (1): 21-27
- [44]. Idler, E. L. & Kasi, S. V. (1995). Self-rated Health: Do they predict change in functional ability? *Journals of Gerontology, Series B, Psychological Sciences and Social Sciences*, 50 (6): S344-S353.
- [45]. Idler, E. L., & Kasl, S. V. (1997). Religion among disabled and nondisabled persons I: Cross-sectional patterns in health practices, social activities, and well-being. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 52(6), S294.
- [46]. Kiely, D. K., Simon, S. E., Jones, R. N., & Morris, J. N. (2000). The protective effect of social engagement on mortality in long-term care. *Journal of the American Geriatrics Society*, 48 (11): 1467-1472.
- [47]. Kiely, D. K. & Flacker, J. M. (2003). The protective effect of social engagement on 1-year mortality in a long-stay nursing home population. *Journal of Clinical Epidemiology*, 56: 472–478.
- [48]. Kodzi, I. A., Gyimah, S. O., Emina J. & Ezeh, A. C. (2010). Religious Involvement, Social Engagement, and Subjective Health Status of Older Residents of Informal Neighborhoods of Nairobi. *Journal of Urban Health Bulletin of the New York Academy of Medicine*, 10.1007/s11524-010-9482-0
- [49]. Kyobutungi, C., Egondi, T. & Ezeh, A. (2010). The health and well-being of older people in Nairobi's slums. *Global Health Action Supplement 2*: 45-53. DOI: 10.3402/gha.v3i0.2138
- [50]. Levy, B. R (2003). Mind Matters: Cognitive and Physical Effects of Aging Self-Stereotypes *Journal of Gerontology: Psychological Sciences* 58B(4): 203–211
- [51]. Lewis, C. A., Shevlin, M., Francis, J. L. & Quigley, C. F. (2011). The association between church attendance and psychological health in Northern Ireland : a national representative survey among adults allowing for sex differences and denominational difference. *Journal of Religion and Health*, 50(4): 986-995.
- [52]. Loewenthal, K. M., MacLeod, A. K. & Cinnirella, M. (2001). Are women more religious than men? Gender differences in religious activity among different religious groups in the UK. *Personality and Individual Differences*, 32: 133-139
- [53]. Mbiti, J. S. (1990). *African philosophy and religion* (2nd ed.). Oxford, England: Heinemann.
- [54]. McCullough, M. E. & Laurenceau, J. (2004). Gender and the Natural History of Self-Rated Health: A 59-Year Longitudinal Study. *Health Psychology*, 23(6): 651-655.
- [55]. McDonough, P. & Walters, V. (2001). Gender and health: Reassessing patterns and explanations. *Social Science and Medicine*, 52: 547–559.
- [56]. McGinnis, L., Shun, S. & McQuillan, J. (2003). A review of gendered consumption in sport and leisure. *Academy of Marketing Science Review* volume 2003 no. 5. Retrieved from <http://www.amsreview.org/articles/mcginnis05-2003.pdf>.
- [57]. Mendes de Leon, C. F., Glass, T. A. & Berkman L. F. (2003). Social engagement and disability in a community population of older adults: The New Haven EPESE. *American Journal of Epidemiology*, 157(7): 633–42.
- [58]. Menec, V. H. (2003). The relation between everyday activities and successful aging: A 6- year longitudinal study. *Journal of Gerontology: Social Sciences*, 58B, S74–S82.
- [59]. Molarius, A., Granstrom, F., Feldman, I., Blomqvist, M. K., Pettersson, H. & Elo, S. (2012). Can financial insecurity and condescending treatment explain the higher prevalence of poor self-rated health in women than in men? A population-based cross-sectional study in Sweden. *International Journal for Equity in Health*, 11: 50. <http://www.equityhealthj.com/content/11/1/50>.
- [60]. Mwanyangala, M., Mayombana, C., Urassa, H., Charles, J., Mahutanga, C., Abdullah, S. & Nathan, R. (2010). Health status and quality of life among older adults in rural Tanzania *Global Health Action Supplement 2*: 34-44. DOI: 10.3402/gha.v3i0.2142
- [61]. Nawi, N., Kowal, P., Kahn, K., Naidoo, N., Abdullah, S., Bawah, A. et al (2010). Health inequalities among older men and women in Africa and Asia: evidence from eight Health and Demographic Surveillance System sites in the INDEPTH WHO-SAGE study. *Global Health Action Supplement 2*: 96-107. DOI: 10.3402/gha.v3i0.5420
- [62]. Njoh, A. J. (2006). *Tradition, Culture and Development in Africa: Historical Lessons for Modern Development Planning*. Ashgate Publishing Limited, Burlington USA, 228pp.
- [63]. Ododo, E. (2001). Theatrical aesthetics and functional values of Ekuechi masquerade ensemble of the Ebira people in Nigeria. *African Study Monographs*, 22, 1-36. Retrieved from [http://jambo.africa.kyoto.u.ac.jp/kiroku/asm\\_normal/abstracts/pdf/22-1/1-36.pdf](http://jambo.africa.kyoto.u.ac.jp/kiroku/asm_normal/abstracts/pdf/22-1/1-36.pdf).
- [64]. Ogunbameru, O. A. (1987). Nigeria: The possible crisis of retirement—An exploratory essay. *African Gerontology*, 1(5), 19–36.

- [65]. Ogunbameru, O. A., & Bamiwuye, S. (2004). Attitudes toward retirement and pre-retirement education among Nigerian bank workers. *Educational Gerontology*, 30(5), 391–401.
- [66]. Okehia-Offoha, M. U. & Sadiku, M. N. O. (1996). *Ethnic and cultural diversity in Nigeria*. Africa World Press Inc. Trenton NJ.
- [67]. O'Toole, S. A. (2006). *African Masquerades: Art and its Importance in African Cultures*. Retrieved from <http://www.chatham.edu/pti/curriculum/units/2006/OToole.pdf>.
- [68]. Perlman, F. & Bobak, M. (2008). Determinants of self rated health and mortality in Russia –are they the same? *International Journal for Equity in Health*, 7(19). <http://www.equityhealthj.com/content/7/1/19>
- [69]. Rodriguez-Galan, M. B. & Falcon, L. M. (2010). Patterns of social activity engagement among older Hispanics and their relationship to sociodemographic and health variables. *Activities, Adaptations & Aging*, 34: 251-274
- [70]. Singh, L., Arokiasamy, P., Singh, P. K. & Rai, R. K. (2013). Determinants of gender differences in self-rated health among older population: Evidence from India. *SAGE Open*, 3:1-12. DOI: 10.1177/2158244013487914
- [71]. Thomas, P. A. (2011). Gender, social engagement and limitations in later life. *Social Science & Medicine*, 73 (9): 1428-1435.
- [72]. Utz, R. L., Carr, L. D., Nesse, R. & Wortman, C. B. (2002). The effect of widowhood on older adult social participation: An evaluation of Activity, Disengagement and Continuity theories. *The Gerontologist*, 4 (2): 522-533.
- [73]. Uwah, I. E. (2011). The representation of African traditional religion and culture in Nigeria popular films. *Politics and Religion Journal* 5(1), 81-102. Retrieved from <http://www.politicsandreligionjournal.com>.
- [74]. Vina, J., Borrás, C. & Miquel, J. (2007). Theories of Ageing. *Life*, 59: 249–254,
- [75]. Wang, H., Karp, A., Winblad, B. & Fratiglioni, L. (2002). Late-life engagement in social and leisure activities is associated with a decreased risk of dementia: A longitudinal study from the Kungsholmen project. *American Journal of Epidemiology*, 155(12): 1081-1087
- [76]. Wolinsky, F. D., Miller, T. R., Malmstron, T. K. Miller, P. J., Schoolman, M., Andresen, E. M., & Miller, D. K. (2008). Self-rated health: Changes, trajectories and their antecedents among African Americans. *Journal of Aging and Health*, 20 (12): 143- 158.
- [77]. Zhang, W. (2010). Religious Participation, Gender Differences, and Cognitive Impairment among the Oldest-Old in China. *Journal of Aging Research*, Article ID160294,10pages doi:10.4061/2010/160294