Subjective Quality of Life and Perceived Adequacy of Social Support among the Elderly in Arbaminch Town

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Abstract

Cultural discourse in Ethiopia appears to retain mixed attitudes about life in the latter years. There is on the one hand, a portrayal of the elderly as socially valued, privileged, respected, and supported. On the other hand, there is a conception that links aging and retirement with sickness, inability, helplessness, and dependency ("ke areju aiyebeju") and going down the hill. However, academic discourse is only emerging and there is a lot more to be done to uncover what it really feels like to be an elderly in Ethiopia. One such major concern pertains to the very general experiences of life of the elderly and associated factors. The purpose of this study was then to specifically assess the subjective quality of life and perceived adequacy of social support and the possible socio-demographic factors making differences in quality of life. Data were collected through questionnaire administered to a sample of 360 elderly (aged 60 and over) in Arbaminch Town. Data analysis was made through descriptive statistics, one-sample-mean test, bivariate correlation analysis, multiple regression, and the forward stepwise variant of multiple regression analysis. Findings indicated that very few elderly had a high quality of life, but the majority had either low or moderate quality of life. Perceived adequacy of social support also took the same pattern contrary to the expectation that the elderly in "developing nations" are believed to enjoy extended social support. Attempts to explain this profile of the elderly yielded that perceived social support and income were indeed the strongest predictors generally explaining about fifty percent of the variance in self-ratings of subjective quality of life. Hence, it was suggested that there is a need to explore other potent factors that would do the remaining fifty percent of the explaining.

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Other recommendations were also suggested to better address the problem in the future.

Keywords: E*lderly in Ethiopia, quality of life, Social Support, Subjective Quality of Life.*

Introduction

The population of older persons is increasing globally overtime. This same pattern appears to follow in Ethiopia, too. According to the Central Statistical Agency (CSA) National Population and Housing Census report, the number of older people aged 60 years and over grew in Ethiopia from 3, 051,962 in 1994 (CSA 1994)to 3, 441,024 in 2007 (CSA 2007); an increase of 389,062 persons in about a decade. It is expected that the years ahead will gradually gather momentum to witness further but remarkable changes in the population dynamics eventually challenging the established view that the Ethiopian society is composed of a population of young persons. This shift in population characteristics obviously stretches itself, *mutatis mutandis*, to the services and provisions, life styles and patterns, and health conditions of the elderly.

The elderly in Ethiopia were commonly regarded as the source of Ethiopia's rich history, custodians and transmitters of culture and tradition, advocates and actors of peace and stability (MOLSA, 2006). Ethiopia has always valued and treasured the elderly to preserve its custom and tradition (MOLSA, 2006). As the case is in many African countries, the elderly are the sources of wisdom, the guardians of the mysteries and the laws in which the cultural heritage of communities is expressed. The common African adage beautifully expresses this idea, "If an African elderly dies, it is a library that burns". Particularly in Ethiopian culture, there is a broad range of practices that really shows the elderly are indeed valued like, for instance, children's respect, obedience, loyalty, material support, and physical care to parents.

However, in more recent years, the elderly seem to have become rather marginalized a great deal in Ethiopia particularly in the cities (HelpAge, 2001). This is possibly because of retirement displacing the elderly to a state of economic dependency. Other possible reasons may include, among

others, changes in the value systems as a result of urbanization, influence of western culture that values youthfulness, and shifts in the dominant source of knowledge from the old to the young.

No wonder then that a large percentage of the older population is becoming more and more vulnerable to a range of problems. These include economic, social, and psychological problems (MOLSA 2006), difficulties adjusting to changing societal values in the modern world causing anxiety, low self-esteem, and depression (HelpAge 2001), and exposure to physical and psychological abuse and neglect forthcoming from significant others including their own relatives and children (Samuel 2005). At a macro level, we can mention lack of formal structure of care and social support networks making older men and women to be largely dependent on the informal traditional family support system, which has become weakened today (HelpAge 2001). In more recent years, many elderly persons are still experiencing challenges of parenting their grandchildren orphaned by parental loss due to HIV/AIDS (Belay and Belay 2010).

In fact, personal experiences also show that the elderly, particularly those with advanced ages, appear to face a range of problems such as declining health, limited income and high cost of living forcing them to make a living through begging. It is as if that there is a mutual withdrawal of them from the society and society from them thereby making their worlds shrink gradually. They don't tend to venture out in the neighborhoods; they stay homebound. They are alone a lot more, families are too busy to visit them, and they have less motivation for self-care and end up losing weight, dehydrated, feeling like burden to their loved ones.

One may argue then that all these challenges tend to pull themselves up together structuring in the final analysis the elderly's overall perceived quality of life.

According to the World Health Organization Quality of Life Group (WHOQOL-Group 1993:34), quality of life is defined as "an individual's perception of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns."

Quality of life is a multidimensional concept and contains both objective and subjective dimensions (Netuveli and Blane 2008). Although attempts were made to assess quality of life of older adults through

objective measurements, it has been realized that the individual's subjective feeling and self-evaluation of their quality of life are also very crucial to the public policy agenda (WHOQOL-Group 1993). Researchers (Qin 2007) have even recognized the importance of subjective evaluations over objective life conditions. Therefore, subjective quality of life has been commonly used in aging studies. Others found that objective and subjective assessments of quality of life were very closely correlated (Lawton et al. 1999).

Subjective Quality of Life (SQOL) is defined as the way people evaluate the significant domains of their life as a whole. How these relevant life domains are evaluated is determined by psychological processes like dispositional optimism, personal characteristics, self-esteem, and locus of control (Qin 2007), socio-demographic characteristics of individuals like age, gender, income level, marital status, educational status, and social positions (Patel et al. 2007, Cummins et al. 2004). Other researchers emphasized the influence of both internal (health, expectations, aspirations, personal beliefs), and external (culture, socio-demographic factors such as age, sex, socio-economic status, education and marital status) factors on quality of life (Carr and Higginson 2001, WHOQOL-Group 1993).

However, researchers investigating the relationship between the psychological processes, socio-demographic factors and subjective quality of life have often failed to examine the influence of perceived adequacy of social support on the individual's subjective quality of life. In fact evidences indicate that social support is one of the important factors that play a major role in maintaining well-being in the aged. McCauley et al. (2000) indicated that the social relations are significant determinants of subjective wellbeing, including perceived satisfaction in life, in older adults. Social relationships are both a source of satisfaction and pleasure in their own right and are important buffer for environmental stressors (MOLSA 2006). Social support has an effect on health by increasing the sense of well-being and reducing vulnerability so that the more social support individuals have, the better their quality of life, regardless of their levels of stress (Uchino 2004). Other researchers have also uncovered that social support is one of the factors affecting the subjective quality of life of the elderly (Gabriel and Bowling 2004, Haller and Hadler 2006, Shippy et al. 2005, Jakobsson et al. 2000, Patel et al. 2007). Furthermore, social support

provides a sense of security and opportunities for companionship and intimacy (McNicholas 2002), and also serves as a coping resource for the elderly to manage uncontrollable situations (Shippy et al. 2005). Similarly, Koukouli et al. (2002) also suggested that social support appears to play a significant role in explaining differences in subjective functioning; people living alone or only with a spouse, particularly the elderly, seem to be at greater risk for disability problems and should receive particular attention from preventive programs in the community. In addition, social support affects quality of life, as evidenced by a study by OHara (2007). The elderly tend to have better quality of life if they receive regular care and support from family members as well as friends and peers (McNicholas 2002, OHara 2007) for older people, particularly those living with stressful life events (Shippy et al. 2005). Family, friends and persons beyond family have been considered as the most important source of support for older persons. Thus, older persons with adequate support from these sources have shown higher self-esteem and life satisfaction (Shippy et al. 2005).

It seems generally that perceived availability of various types of social support would moderate stressful events and advance subjective quality of life. However, only limited information is available concerning the impact of social support on the reconstruction of quality of life particularly when it is weighed along other possible contributing factors like income, education, marital status and others. Furthermore, studies examining the influences of age, marital status, education, and income have utilized inconsistent definitions of the variables involved and this would obviously lead to discrepant findings. Yet, their combined and independent effects were not also thoroughly examined. Still important is the fact that, despite all these exercises to examining quality of life of the elderly, research on the elderly in itself is less visible in Ethiopia; not to talk of specific issues leading to miniature theorizing. Some of the research done in the field is briefly presented here under.

Research on the elderly in Ethiopia

Research on the elderly was non-existent in Ethiopia nearly a decade ago. In fact, there appeared a breaking of the silence nearly a decade after a researcher once lamented, “Ethiopian adolescents seem to enthrall researchers more than children and adults. Whether the elderly can ever get

the clemency of researchers in the years to come is hard to tell" (Belay 2008: 18).

Relatively speaking, the oldest and yet relevant research was a (pension) policy analysis in which pension contributions were found consistently falling far short of pension payments resulting in large national budget deficit and yet the level of pension benefits were found to remain very small and unresponsive to increases in the cost of living (Gebrehiwot 1991). Years later, Abdella (2005) explored the role, status and perceived social support of the elderly in the Gedeo community and portrayed them in terms of both positives (were playing various roles, receive social respect and support from family members) and negatives (had physical problems, difficulties meeting basic needs, and socio-economic problems).With the view to checking the social position of the elderly and its impact on social and psychological functioning, Mahlet (2007) examined in another study the attitude of the Tehuledere community of the Dessie Zurea Woreda towards Abegar members and non-members. She found that the former were more respected, more favorably treated, better engaged in social activities like mediation of people in conflict, and retained better self-views and psychological wellbeing (Mahlet 2007). In about the same area, Kassahun (2007) investigated the support the elderly received from their adult children. He found that the elderly retained lesser contact with their adult children, they preferred to stay with sons but daughters had more contact, and sons were better in providing financial and material support than daughters. While adult children provided better social support than relatives, neighbors, and close friends, emotional and moral support came, however, more from neighbors and close friends (Kassahun 2007).

Other studies focused rather on psychological profile of the elderly (Tomas 2007, Tilahun 2010, Girum 2012) in different settings: Kaliti Home for the Aged (Tomas 2007), Dangila Town (Tilahun 2010), and Dessie Town (Girum 2012). Tomas (2007) found out that the psychosocial profile of the elderly before admission into Kaliti Home for the Aged was much lower than their profile after admission showing that for the elderly considered in the research even life in institution is better than outside. On the other hand, Girum (2012) explored the psychological wellbeing as a function of religious involvement, spirituality and personal meaning in life among community-residing elders. He found that most elders had moderate

score on self-esteem, autonomy and depression and males were consistently better in psychological well-being.

A more specific dimension of psychological profile that was closely examined among the elderly in Ethiopia was "self-esteem" (Belaynesh 2007, Zeru 2009, Belay 2010). Some researchers investigated self-esteem of the elderly along with such other variables as activity engagements (Belaynesh 2007); depression, loneliness, and coping mechanisms (Zeru 2009); and age, sex, income, education, and perceived adequacy of support (Belay, 2010) in Addis Ababa (Belaynesh 2007), Dangila (Zeru 2009), and Debre Markos (Belay 2010) towns. According to Belaynesh (2007), the elderly with multiple roles had the highest self-esteem while engagement in a work role did not make significant differences in self-esteem compared with socio-cultural roles, and when work engagement was important, those engaged in work roles by choice had better self-esteem than those who engaged by necessity. Examining possible factors affecting self-esteem of the elderly, Belay (2010) reported a decrease in self-esteem with age, no difference in self-esteem by sex, but a positive relationship of self-esteem with income, education, and perceived adequacy of support. Zeru (2009) examined self-esteem along with such other variables as depression, loneliness, and coping problems and reported a prevalence rate of 26%, 8.7%, and 2.7% respectively.

Belay and Belay (2010) examined the situation of the elderly affected by HIV/AIDS in Addis Ababa and Chilga, Gondar and indicated that nursing sick adult children, mourning their loss, grand parenting children under limited resources, and financial constraints were some of the added common problems of the elderly in most recent years. Samuel (2006) examined the abuse and neglect of the elderly in the streets of Addis Ababa and in the homesteads and found there were serious abuses in both settings.

The present study attempts to address a more substantive issue of the elderly-quality of life and associated factors in a setting in which the society is, in many instances, age-graded and it is believed that being aged is a promotion than a demotion particularly in the rural societies.

Objectives

The present study attempts to assess the status of the subjective quality of life, and perceived adequacy of social support of the elderly, patterns of

quality of life across the selected socio-demographic factors (sex, age, educational status, marital status, and income) and social support level, and combined and independent contribution of demographic variables and social support in predicting quality of life.

Methods

The present study was conducted in Arbaminch Town. Like many other Ethiopian towns, the number of older persons in Arbaminch is increasing; and personal experience shows that this increase has brought some difficulties particularly for those (e.g. religious) institutions in the town which are trying to provide some assistance to this group.(e.g. religious) in the Town which are providing some assistance to this group. It was observed that religious institutions providing different support (like food and clothes) for the elderly expressed a concern that they were overwhelmed with the rising number of the needy. These institutions mentioned in different ways that they could not provide adequate support for the elderly. On the other hand, Arbaminch is less urbanized and it seems to retain the characteristics of rural communities where the elderly are likely to be respected, retain properties or assets of their own, and live with these assets and in the homestead. In the face of these contradictions, it is inspiring then to examine the elderly's perceived support and its impact on quality of life in this area.

The population of this study consisted of the elderly people in Arbaminch Town. Arbaminch has four major sub-city administrations (Shecha, Nech Sar, Sikela, and Abaya) containing eleven kebeles. From these, five kebeles were randomly selected having a total population of 1117 (505 males and 612 females) elderly; and this was the target population or the sampling frame. A sample of 391 participants (35% of the population) were randomly selected (168 males and 223 females) as participants from this population. The procedure of selection was that the names, villages, and house numbers of persons aged 60 and above were secured from the list of dwellers in each of the five kebeles. Then a random sample of about 67 to 100 participants was proportionately selected from each kebele. However, 31individuals were excluded from the analysis due

to incomplete data. Table 1 presents the distribution of the sample by the five kebeles and gender.

Table 1: Distribution of Sample Size

Kebeles	*Actual Number*			*Sample Size*				
	Male	*Female*	*Total*	*Male*	*%*	*Female*	*%*	*Total*
Kulfo	157	267	424	45	11.5	55	14.0	100
Menaherya	90	94	184	33	8.43	43	10.99	76
MehalKetema	92	68	160	30	7.67	42	10.74	72
WuhaMnch	54	49	103	26	6.64	41	10.48	67
Chamo	112	134	246	34	8.69	42	10.74	76
Total	505	612	1117	168	42.93	223	56.95	391

Data was collected through questionnaire composed of three parts: socio-demographic characteristics of respondents, subjective quality of life, and perceived social support. The socio-demographic section included items about the age, sex, educational level, marital status and income of the participants.

The measure for subjective quality of life is the most frequently used instrument for assessing quality of life, "WHO QOL-26". This tool consists of 26 items and was derived from the (WHO) QOL-100 items pool. It includes seven items in the physical domain (physical state), six items in the psychological domain (cognitive and affective state), three items in the social domain (interpersonal relationship and social role in life), eight items in the environmental domain (relationship to salient feature of the environment), one item for general quality of life, and one item for health-related quality of life combined together as a global domain. Participants are to rate their level of satisfaction or agreement with each item on a five point rating scale (1=strongly disagree…5=strongly agree) (WHOQOL-Group, 1993). Attempts were made to customize this measure in terms of relevance and wording. The third set consists of the Multidimensional Scale of Perceived Social Support (Zimet et al. 1988). It is a twelve item scale to be rated on a three point Likert-type scale, ranging from (1) disagree to (3) agree. It measures social support from three sources: family, friends, and a special person. Once the data were collected, the responses were coded

reversing negative statements into a positive direction, and then entered into SPSS version 16 for computation.

Data analysis was carried out in such a way that first and foremost attempts were made to examine the general nature of data (on demographic characteristics, quality of life and perceived social support) using frequency distributions and descriptive statistics. Then, one sample mean test was applied to determine the significance of quality of life and perceived social support. Having checked the significance of occurrences of these variables then followed a successive analysis to determine the factors affecting the subjective quality of life. This begun with a simple analysis of bivariate correlation among variables: predictor (demographic factors and perceived social support) and criterion variables. This was used as a foundation to determine if further analysis was needed and the type of such analysis. Accordingly, the bivariate correlation suggested the need for a further analysis to determine the combined effects of predictors, analyzed through multiple regression, as well as the need to partial out overlaps and determine net effects or independent contributions of each predictor variable, analyzed through the stepwise variant of multiple regression.

Findings

Demographic Characteristics

A total of 360 elders were involved in data analysis. Out of these, 155 (43%) were males and the rest 205 (57%) were females. The age of respondents ranged from 60 to 94 years with the mean age of 68.48±6.88 years. Out of this, 116 (32.2%) of them were young elders (60 to65 years), 97 (26.9 %) were middle elders (66to69 years), and the remaining (40.8%) relatively higher number were late elders (over 70 years)[2]. With respect to

[2] Social gerontologists often divide older people into three subcategories: young elders (people 65 to 74 years); middle elders (people 75 to 84 years); and late elders or "oldest old" (people 85 or older) (see J. Quadagno, 1999). This classification was modified for our present purpose to fit the Ethiopian context where the average life expectancy is 49 years.

educational level, 198 (55.0%) were illiterate, 73 (20.3%) had received basic education, 51 (14.2%) had received primary education, 29 (8.1%) had high school education, and only 9 (2.5%) had college/university education. In addition, 50 (13.9%) were married (living with their spouse) while the rest were non-matrimonial: 6 (1.7%) unmarried, 169 (40.9%) widowed, 103 (28.6%) divorced and 32 (8.9%) were separated.

The source of income for respondents was private business (30.30 %), government pension (17.8%) fund from NGO/government (5.30%), children/relative (20.80%, less desirable source of income (including begging, cottage work, and daily labor) (22.80%), and other monthly income (3.10%). Their major sources of livelihood were generally reported to include begging, petty trade, pension benefits, family support, community support, religious institutions' support, daily labor, and involvement in cottage industries. As per their own estimation of monthly income, it was found that more than half of the elderly had an income of less than Birr 500.00, and 6.10% earned between Birr 500.00 and 1000.00, and the rest 7.50% had an income of more than Birr1000.00. The median income per month was Birr 400.00 (M=481.46, SD=411.026), with the lowest being Birr 50.00 and the highest Birr 2000.00.

Subjective Quality of Life

Patterns of Subjective Quality of Life

In an attempt to examine the patterns of subjective quality of life of the elderly, descriptive statistics of respondents is presented (Table 2) on the four dimensions (physical, psychological, social, and environmental wellbeing) on Table 2.

Table 2: Descriptive Statistics for the Four Dimensions of Subjective Quality of Life (N=360)

Domain	Statistics								
	N	**No. of items**	**Min**	**Max**	**Mean**	**SD**	**Expected Mean**	**Mean diff.**	**t-value**
Physical health	360	7	9.00	27.0	18.62	3.13	21	-2.38	112.65

Psychological wellbeing	360	6	6.00	24.0	14.88	3.43	18	-3.12	82.28**
Social relationship	360	3	3.00	13.0	9.06	2.29	9	.06	-
Environmental wellbeing	360	8	12.0	31.0	20.01	4.12	24	-3.99	92.11
Total	**360**	**24**	**-**	**-**	**62.58**	**10.17**	**72**	**9.42**	116.74

Remark: Expected Mean= (number of items) X (mid-point of the rating scale)
*** P<0.000, df=359*

The descriptive statistics are explained using the expected mean as a framework. If the calculated mean is below the expected mean, it is considered to suggest low score while if it is equal or exceeding the expected mean, it is interpreted as a high score. Accordingly, the descriptive statistics on Table 2 indicates that the mean ratings of the elderly on almost all the measures are less than the expected mean ratings. More specifically, the mean score on physical strength (18.62) appears lower than the expected (21) indicating that the elderly don't seem satisfied with their physical health. In the same way, the expected mean of psychological wellbeing (18) is still greater (than the calculated mean= 14.88) indicating again that the elderly do not seem satisfied on their psychological well-being. The same is true for environmental wellbeing in which the expected mean (24) appears much higher than the calculated (20.01). In fact, social relationship is better in the sense that the expected (9.00) and calculated mean (9.06) appear more or less comparable. One sample mean test was conducted to check the significance of the differences above and the test result yielded that these differences are significant.

Global Domains of Quality of Life of the Elderly

In addition to the four measures of subjective quality of life, attempts were also made to check the global domains of quality of life using two important items (Table 3).

In item 1, the elderly were asked to rate their general quality of life. It can be noted from data on this table that over 72% of the elderly rated their quality of life as poor and very poor, while the remaining smaller

proportion (19%) perceived their quality of life as good or very good. The mean rating score on the first items (M=1.99 and SD=1.23) appears to lie between very poor and poor; implying that the elderly rated their quality of life nearly as poor.

Table 3: Patterns of Subjective Quality of Life of the Elderly on the Overall Quality of Life and General Health Items (N=360)

Items	Rating Scale	Responses		Mean	SD	Expected Mean	Mean diff.	t-test
		Freq.	%					
1. General quality of life	V. poor (=1)	187	51.9	1.99	1.2	3	1.01	30.559 *
	Poor (=2)	69	19.2					
	Undecided (=3)	33	9.2					
	Good (=4)	62	17.2					
	V. good (=5)	9	2.5					
2. Satisfaction with health	V. dissatisfied (=1)	125	34.7	2.39	1.4	3	0.61	32.137
	Dissatisfied(=2)	108	30.0					
	Undecided(=3)	39	10.8					
	Satisfied (=4)	37	10.3					
	Very satisfied (=5)	51	14.2					
Total		360	100%					

Note: P<0.05 df=359

Concerning satisfaction with health, the greater majority (64.70%) of the respondents are 'dissatisfied' or 'very dissatisfied' where as 24.50% were 'satisfied' or 'very satisfied'. About 10.80% indicated that they are 'neither satisfied nor dissatisfied'. The overall rating of satisfaction with their health is closer (2.39) to the scale point "dissatisfied" (=2.00). The test result also yielded that the observed mean significantly departs from the expected one.

Perceived Adequacy of Social Support

The study also aimed to assess the perception of the elderly about the adequacy of social support received from family members, friends and significant others (see Table 4).

Looking into the responses to the family sub-scale items (item 1, 2, 3, and 4), it can be noted that a large number of the elderly (45.00%) seemed

to indicate that they can't get any support from their family (Item 1) or are unhappy about family support (47.20%) (Item 2), can't talk about their personal problems with the family (49.40%)(Item 3), and their family, too, is not willing to help them make decisions in their life (43.10%)(Item 4).

With regards to friend's support (items 5, 6, 7 & 8), the data (Table 4) still shows that more than half of the elderly responded negatively about friends' support as well as support received from significant others. Support from special person (Items 1, 2, 3 and 4) is even much lower than support from friends, significant others, and family support.

The overall mean rating on the Perceived Adequacy of Social Support scale is generally significantly lower than the expected mean; which implies that the elderly seem not satisfied with the availability of social support from their family, friends, significant others, and any other person special to them. We would generally say that there is a lower level of perceived adequacy of social support among the elderly in Arbaminch Town.

Table 4: Perceived Adequacy of Social Support among the Elderly(N=360)

Sources of support		Rating values						Mean
		Disagree=1		Undecided=2		Agree=3		
		Freq.	%	Freq.	%	Freq.	%	
Family support	My family really tries to help me	162	45.0	66	18.3	132	36.7	1.91
	I get the emotional support I need frommy family	170	47.2	122	33.9	68	18.9	1.71
	I can talk about my problems with my family	178	49.4	76	21.1	106	29.4	1.80
	My family is willing to help me makedecisions	155	43.1	120	33.3	85	23.6	1.80
	Total family support	-	-	-	-	-	-	**1.81**
Friends	My friends really try to help me	201	55.8	94	26.1	65	18.1	1.62
	I can count on my friends when things gowrong	191	53.1	130	36.1	39	10.8	1.57
	I have friends with whom I can share myjoys and sorrows	203	56.4	74	20.6	83	23.1	1.66
	I can talk about my problems with myfriends	175	48.6	62	17.2	123	34.2	1.85
	Total friends' support	-	-	-	-	-	-	**1.68**
Special persons	There is a special person who is aroundwhen I am in need	202	56.1	76	21.1	82	22.8	1.66
	There is a special person with whom Ican share joys and sorrows	219	60.8	69	19.2	72	20.2	1.59
	I have a special person who is a realsource of comfort	218	60.6	76	21.1	66	18.3	1.57
	There is a special person in my life whocares about my feelings	218	60.6	102	28.3	40	11.1	1.50
	Special persons' total support							**1.58**

Factors Affecting Subjective Quality of Life

It is the major purpose of our analysis to determine the extent to which the selected socio-demographic factors and perceived adequacy of social support (predictor variables) account for variance in the rating of subjective quality of life (criterion-variable) separately and in combination. The procedure is that we first examine the inter-correlation matrix to check bivariate correlation among variables and the significance of multiple correlation of predictors with the criterion variable. When significant correlations are obtained, then further analysis will be made to partial out the overlaps and then determine the net contribution of each predictor in explaining the criterion variable.

Bivariate Correlation among the Variables

One of the basic questions of this study was to check whether there exists relationship between predictor variables (sex, age, educational level, marital status, monetary income and perceived adequacy of social support) and subjective quality of life. The correlation matrix on Table 5 presents the inter-variable correlation coefficients.

Table 5: Inter-correlation Matrix among all the Variables (N=360)

Variables	Inter-correlations					
	Sex	Age	Educ.	MS	MI	SS
1. Sex (0=Male, 1=Female)						
2. Age	.055					
3. Education Level (Educ.)	-.106*	-.290**	-			
4. Marital Status (0=non-married, 1=married), (MS)	-.153**	.026	-.449**			
5. Monthly Income (MI)	.077	-.113*	.530**	-.648**		
6. Social Support (SS)	-.044	-.177**	.416**	-.459**	.510**	
7. Total SQOL	.096	-.141	.430**	-.461**	.690**	.475**

***P<.05** ***P<.01**

As shown on Table 5, sex and age are not significantly correlated with subjective quality of life (r=.096, P≥.05; r=-.141, P≥.05 respectively). On the other hand, significant correlation was found between subjective quality of life and the predictor variables: educational level (r=.430, P<0.05), marital status (r= -.461, P<0.05), monthly income (r=.690, P<0.05), and perceived adequacy of social support (r=.475, P<0.05). Note on Table 5 also that there are significant correlations between predictor variables themselves. This means that there is a need to test for independent contributions of these variables by partialing out the overlaps within them. This would require making use of a statistical model that accommodates more than one predictor variable and regress it on the predicted variable. Table 6 presents summary of the results of multiple regression analysis and Table 7 presents the stepwise regression analysis.

Combined Contributions of Predictor Variables

The multiple regression of subjective quality of life fitted by accommodating all the predictor variables having significant bivariate correlation with the criterion variable is presented on Table 6. This table shows that the overall F-ratio is significant ($F_{4,355}$=88.283, P<0.05).

Table 6: ANOVA Summary Table for Multiple Regression Analysis

Source of variance	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Regression	24162.359	4	6040.590	88.283	.000
Residual	24290.305	355	68.423		
Total	48452.664	359			

Note: *The criterion variable is subjective quality of life and predictors in the model are social support, educational status, marital status, monthly income.*

Independent Contributions of Predictor Variables on Subjective Quality of Life

The total F-ratio obtained by four predictors combined was shown to be significant. But, it was also shown that there are significant bivariate correlations between these predictors themselves. The within predictor correlations need to be partialed out to determine the net effect of each predictor. Hence, in order to identify the independent predictors of subjective quality of life, a stepwise multiple regression analysis was performed using variables having significant correlation with the dependent variable. Table 7 presents the summary of stepwise regression in which the model completed selection of candidates for inclusion in the second step or after picking up only two predictors. The rest two variables were totally consumed with the overlap; thus adding nothing more than the overlap they had with the other predictors.

Table 7: Model Summary Table for Stepwise Multiple Regression Analysis (N=360)

Step no.	*Variables Entered*	*R*	R^2	*Changes in* R^2	*Beta weight*	*Test of significance*
1	Monthly Income	.690	.475	.475	.690	.000
2	Social Support	.704	.496	.021	.167	.000

As it can be seen on Table 7, monthly income and social support combined explain about 49.60% of the variance in subjective quality of life (F (2, 357) = 175.715, p<.000). That is, variables other than those considered in this study are to account for the remaining 49.40% of the variance in the elderly ratings of subjective quality of life. This suggests then the presence of other factors of subjective quality of life that would make important contribution in explaining this variable.

The (stepwise) regression analysis shows that monthly income of the elderly added significantly to the prediction of subjective quality of life [$F_{(1,358)}$ = 324.554, p<.000)], accounting for 47.50% of the variance. Entrance of social support to the original equation in the second step has improved the prediction of subjective quality of life by about 2.10% (F $_{(2,357)}$)

= 175.715, p<.000). That is, each predictor variable has made a significant independent contribution in explaining subjective quality of life.

Discussions

This research was done in Arbaminch to explore the quality of life of the elderly and possible factors explaining why it was the way it happened. Participants were 360 elderly with a surprising mean age of about 68 years. This is an age that stands in sharp contrast to the average life expectancy of the general population in the western nations (80 years and above) that includes children and adolescents. It was also noted that more than 86% of these elderly were out of marital relationship for one reason or another. A fifth of the elderly were engaged in unattractive or less desirable income generating activities like begging or age-unfriendly jobs like cottage work, and daily labor. The income of the elderly was either precarious for many or stable for the rest (as in pensioners) but smaller on the average than even the minimum wage for civil servants in Ethiopia (i.e. Birr 500.00).The inadequacy of the pension benefit was repeatedly commented in the past (see Gebrehiwot 1991). In fact, difficulties meeting basic needs and socio-economic problems were also found to characterize the elderly even in rural communities (Abdella 2005).

With this as a background, it may not be a surprise to note that the majority of the elderly had either a low or moderate quality of life. In fact, in previous research, Tomas (2007) indicated that the life of the elderly in the communities was so desperate that even joining a residential care (i.e. Kaliti Home for the Aged), normally critiqued to be a less friendly caring environment, was found to improve the psychological profile of those admitted. Other investigations conducted even in rural settings have also reported that the community-residing elders had moderate score on self-esteem, autonomy and depression (Girum 2012).

We may need to qualify why quality of life among the participants was not that satisfactory. Perhaps social support could be a major explanatory factor. In countries where interdependence is a norm, social support would definitely become a salient source of empowerment not only psychologically but also materially. As indicated earlier, different literature argue the important role social support plays in clicking effectively at the

internal or affective aspects of people's lives, yielding satisfaction and pleasure, buffering environmental stressors by improving coping, and ensuring sense of security and opportunities for companionship and intimacy (MOLSA 2006, Gabriel and Bowling 2004 Haller and Hadler 2006, Shippy et al. 2005, Jakobsson et al. 2007, Patel et al. 2007, McCauley et al. 2000). Particularly, McCauley and colleagues (2000) have indicated that the social relations integral to an exercise environment are significant determinants of subjective wellbeing, including perceived satisfaction in life, in older adults. Baarsen (2002) indicated that the elderly who had lost a partner experienced lower self-esteem, resulting in higher emotional and social loneliness, that is, the perception of less support.

This being the case, the present research indicated, however, that only few elderly had a high social support while the majority had either a low or moderate level of social support. This social support would be compromised for different reasons. To begin with, many of them were not in a matrimonial relationship. Research indicates that married people are more psychologically stable, healthier, happier, and satisfied than singles (cited in Bentley 2007: 39). In fact, a significant correlation was found in this study between marital status and subjective quality of life, but when the overlap this variable has with other predictors was removed, its net effect was insignificant. It is believed that social support is possibly more inclusive consuming at the same time the possible contribution of marital status.

Social support was perceived to be lower in this study also because friendship, companionship, and association with others may eventually shrink with age due to death, change of location and life style following retirement and other factors. According to Seada (2012), more social engagement (in Idirs, family visits/contacts, relationships, association with old and new friends) of the elderly in Addis Ababa was found to be associated with better adjustment in the latter years. The fact that our society and culture are in transition as a result of urbanization, globalization, and economic demands would still constrict the potential role of social support for the elderly.

In a manner that social support was affecting subjective quality of life, the findings of this research also suggested that monthly income stood out conspicuously as a strong predictor of subjective quality of life. As expected, the more financially adequate older individuals felt better quality

of life as they reported. This is also in line with reports from previous research (Cummins and Lau 2004). Supporting this finding, Moller (2004) also showed that income is even more an influential predictor of quality of life than other variables like race. Of course, Baarsen (2002) also reported that socio-economic status and educational attainment have also been found to be positively related to subjective quality of life. Similarly, the independent contribution of education was found in this research to be insignificant as the case is for marital status. That is, the role of education was not found to be more than its economic empowerment because when the correlation between education and income was partialed out during model building, the contribution of education became almost insignificant. So, "income" includes in it education plus something more but affecting subjective quality of life. This finding was consistent with Haller and Hadler's (2006) findings that education did not have a significant effect on quality of life.

Finally, it was noted that the relationship of sex and age to quality of life was found in this research to be inconsistent with some of the findings of previous studies (Bowling et al. 2003, Bowling et al. 2002). For example, Baarsen (2002) found in a USA health population survey that lower quality of life was related to being female. Similarly, research findings by Neg et al. (2006) strengthen the above study results.

Conclusions

In the light of the data presented and the analysis carried out earlier, it can generally be concluded that:

1. A statistically significant proportion of the elderly in Arbaminch had either moderate to low level of quality of life.
2. In the same way, a statistically significant proportion of the elderly had either a low or moderate level of perceived social support.
3. Social support and income were the two single most predictors of subjective quality of life. In combination, these two predictors explained nearly 50% of the variance in self-ratings of subjective quality of life.
4. The remaining 50% were to be explained by factors other than age, sex, education and marital status because the independent contribution of these predictors was statistically insignificant.

Recommendations

The goal of development is successful aging. The core of successful aging is quality of life. Hence, if the perceived quality of life is at stake, it seriously compromises successful aging and thereby reinforces the negative portrayal of the elderly. It is, therefore, recommended to take the following measures to improve subjective quality of life among the elderly:

- Encourage, empower, and support the elderly to retain former social networks (of relationships, sources of support, engagements, and responsibilities) that faded away because of constriction in the environment of the elderly, or help them develop newer social network, or modify inappropriate ones and enrich their life through better engagements.
- Assist the elderly to organize themselves and create self-help advocacy group that would help articulating their life conditions to the public, government and NGOs and effect (attitude, policy and legislative) changes.
- Put into effect the social welfare policy that claims to ensure a better support scheme particularly for elderly who don't enjoy pension benefits.
- The economic situation of older people needs to be supported through policy action to help them stay economically stable for longer, in both formal and informal sectors.
- Rehabilitation centers, institutional care (for the homeless, destitute, and frail), and community-based support need to be put in place for those with special needs
- The educational institutions, government offices like MoLSA and Civil Service Commission, non-government organizations like HelpAge International, and Faith-Based organizations supporting the elderly need to work in collaboration to design strategies and programs that would enhance quality of life of the elderly through improving social support and income.

- Organizing life skills training is still believed to be helpful for the elderly so as to effectively cope with the developmental challenges of the latter years
- Further research needs to be conducted to identify other potent predictors (of subjective quality of life) explaining the remaining 50% of the unexplained variance.

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