

Beyond Chronological Age: Perceptions of Ageing, Functional Ability and Quality of Life Among Community-Dwelling Nigerian Older Adults

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Abstract

Background: Perceptions of ageing, functional ability, and quality of life are important dimensions of healthy ageing. However, evidence on the relationships among these factors among community-dwelling older adults in Southeast Nigeria remains limited. This study examined perceptions of ageing, functional ability, and quality of life among community-dwelling older adults in Enugu, Southeast Nigeria.

Methods: An analytical cross-sectional study was conducted among 119 community-dwelling older adults aged ≥ 60 years. Perceptions of ageing, functional ability, and quality of life were assessed using the Perception of Ageing Questionnaire, Global Activity Limitation Index (GALI), and WHOQOL-BREF, respectively. Descriptive statistics summarized participant characteristics and study variables. Spearman's rank-order correlation examined relationships between perceptions of ageing and quality-of-life scores, while the Kruskal–Wallis H test compared scores across functional-ability categories. Bonferroni-adjusted post-hoc comparisons were performed following significant tests. Statistical significance was set at $p < 0.05$.

Results: Participants had a mean age of 67.08 ± 8.41 years, with 58.0% being female. Functional limitation was present in 49.6% of participants. The highest Perception of Ageing domain score was for positive consequences (4.03 ± 0.69). Social Relations had the highest WHOQOL-BREF domain score (65.17 ± 16.75), while Environment had the lowest (53.65 ± 15.35). Perception of Ageing differed significantly across functional-ability categories ($\chi^2 = 8.177, p = 0.017$), with a significant difference between participants with no limitation and those with non-severe limitation (adjusted $p = 0.038$). No significant correlations were observed between Perception of Ageing and quality of life.

Conclusion: Functional limitation was common among participants, while perceptions of ageing varied across functional-ability categories. However, perceptions of ageing were not significantly associated with quality of life.

Introduction

The world is experiencing a progressive shift in the age structure of its population, with an increasing proportion of people living into older age. Population ageing, which became increasingly evident globally during the second half of the twentieth century, is expected to continue over the coming decades (Nwachukwu et al., 2023). Between 2021 and 2050, the proportion of the global population aged 65 years and above is projected to increase from less than 10% to approximately 17% (United Nations, 2023). This demographic transition has important implications for health and social care, particularly because ageing does not affect all individuals in the same way (Uchenwoke et al., 2026). While some older adults maintain good physical and functional capacity well into later life, others experience varying degrees of functional limitations that may affect their ability to perform activities of daily living independently.

Ageing is a lifelong process that begins at birth and involves progressive biological, physiological, psychological and social changes. Ageing is associated with a range of physiological and cognitive changes. While some changes represent normal aspects of ageing, progressive deterioration in physiological and cognitive function may contribute to functional limitations, increased susceptibility to disease, and disability among older adults (Seals & Melov, 2014; Calero et al., 2020). Changes in perception and cognition have also been reported as part of the ageing process (Roberts & Allen, 2016). However, chronological age alone does not adequately describe the experience of ageing, as older adults of the same age may differ considerably in their physical capacity, psychological well-being, social relationships and ability to remain independent.

Functional ability is particularly important in determining how older adults experience later life (Wickramasinghe et al., 2022). Ageing may be accompanied by changes that affect mobility, self-care and the ability to participate in everyday activities. Although advancing age is an important risk factor for several chronic conditions, the functional consequences of ageing vary substantially between individuals (National Institute on Aging, 2020). This variation has contributed to increasing interest in ageing beyond chronological age, with greater attention being given to the factors that enable older adults to remain active, independent and engaged in their communities (Ingrand et al., 2018).

One factor that may influence the experience of ageing is how older adults perceive and understand the ageing process. Perceptions and attitudes toward ageing can influence how individuals respond to age-related changes, maintain social relationships and engage in health-promoting behaviours (Velaithan et al., 2024). Successful ageing has therefore been described from both objective and subjective perspectives. Objective approaches commonly emphasise the absence of disease and disability and the preservation of physical functioning, whereas subjective approaches place greater emphasis on psychological well-being, social connectedness, adaptation and an individual's perception of their own ageing experience (Jeste et al., 2010). These perspectives suggest that ageing should not be understood solely in terms of the presence or absence of disease, but also in relation to how individuals adapt to changes associated with later life.

The social and psychological consequences of ageing can also influence the well-being of older adults. Retirement, bereavement, declining physical capacity and the development of chronic health conditions may require older adults to adapt to substantial changes in their daily lives (Khan et al., 2024). These experiences may contribute to feelings of loneliness, sadness, reduced self-esteem, helplessness or concerns about becoming dependent on family members (Alemu et al., 2025). Changes in family structures and social support systems may further increase these challenges, particularly in settings where families have traditionally played a major role in caring for older adults (Schulz et al., 2020).

Quality of life is consequently an important outcome when considering the health and well-being of older people. It encompasses more than physical health and includes psychological well-being, social relationships, environmental circumstances and an individual's perception of their position in life (Ingrand et al., 2018). Maintaining functional ability and meaningful social participation may therefore

contribute substantially to a better quality of life among older adults (Dehi Aroogh & Mohammadi Shahboulaghi, 2020).

Despite the growing number of older adults in Nigeria, evidence on the relationship between perceptions of ageing, functional ability and quality of life among community-dwelling older adults remains limited, particularly in Southeast Nigeria. A better understanding of these relationships may help identify factors that can be addressed through community-based health promotion, rehabilitation and social support interventions. Such evidence is also important for developing strategies that move beyond chronological age and focus on maintaining independence, participation and well-being among older adults.

Therefore, this study aimed to examine the relationship between perceptions of ageing, functional ability and quality of life among community-dwelling older adults in Southeast Nigeria. Specifically, the study assessed older adults' perceptions of ageing, evaluated their functional ability, determined their quality of life, and examined the associations among these variables.

Methods

Study Design and Setting

A community-based analytical cross-sectional study was undertaken to investigate the relationship between perceptions of ageing, functional ability and quality of life among older adults living in the community. The study was conducted in Uwani, Enugu South Local Government Area, Enugu State, southeastern Nigeria. Uwani forms part of the wider Enugu metropolitan area and has a predominantly urban residential setting. Participant recruitment and data collection were integrated into a health outreach programme targeted at older residents of Uwani.

Study Population and Eligibility

The study population consisted of community-dwelling adults aged 60 years and above who were residing in Uwani during the study period. Both male and female older adults were considered eligible. Participants were included if they were aged ≥ 60 years, had been resident in the community, attended the outreach programme, provided informed consent, and were able to respond to the study questions and assessment procedures. Participants were excluded if they were acutely ill or medically unstable at the time of assessment, had severe hearing, speech, or visual impairment that could not be adequately accommodated during the assessment, had a known severe cognitive or psychiatric condition that prevented reliable participation, or were unable to complete the study assessments. Individuals who declined to provide informed consent were also excluded from the study.

Sample Size Determination

The minimum required sample size was estimated using G*Power statistical software based on the parameters specified for the study, resulting in a minimum sample of 120 participants. A total of 120 older adults were initially recruited. Following data screening, one questionnaire was excluded due to incomplete responses. The final dataset therefore comprised 119 participants for analysis.

Participant Recruitment

Recruitment was conducted through a community-based health outreach programme. Information about the programme and the opportunity to participate in the study were disseminated through churches and other community contacts before the outreach. Older adults who attended the programme were informed about the study and screened against the eligibility criteria.

Those who met the inclusion criteria and agreed to participate provided informed consent before enrolment. Eligible participants were recruited consecutively until the predetermined sample size was attained. The study did not involve household enumeration or household-level sampling. Data was obtained directly from participants through interviewer-administered questionnaires.

Data Collection Instruments

Data was obtained using a structured questionnaire together with standardized instruments relevant to the study objectives.

Sociodemographic and Background Information

A researcher-developed questionnaire was used to collect information on participants' age, sex, marital status, educational attainment, employment status, religion, smoking history, alcohol consumption, number of children and relevant family or health-related characteristics.

Perceptions of Ageing

Perceptions of ageing were assessed using B-Ageing Perception Questionnaire. It is a concise, multi-dimensional measure of ageing perceptions. The concise version preserved the internal consistency and construct validity of the original scale. The brevity of the 17-item instrument graded on a five-point Likert scale makes it particularly suitable for use with large-scale adult population surveys (Sexton, King-Kallimanis, Morgan & McGee in 2014).

Functional Ability

Functional ability was assessed using the Global Activity Limitation Index (GALI). The GALI assesses whether a health problem has limited an individual in activities that people usually perform for a period of at least six months. Responses distinguish between individuals who are severely limited, limited but not severely, and not limited in their usual activities (Van Oyen et al., 2006). For the purposes of the

analysis, participants were classified as having activity limitation when they reported being severely limited or limited but not severely, or no activity limitation.

Quality of Life: Quality of life was assessed using the World Health Organization Quality of Life-BREF (WHOQOL-BREF). The instrument consists of 26 items covering four domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environment (8 items). It also includes two general items assessing overall quality of life and general health. Each item is rated on a five-point response scale, and domain scores are transformed to a 0–100 scale according to the recommended scoring procedure (Vahedi, 2010). The physical health domain assesses including mobility, activities of daily living, functional capacity, energy, pain and sleep. The psychological domain covers aspects such as positive and negative feelings, self-esteem, body image, cognition and concentration, learning and memory, and personal beliefs. The social relationships domain assesses personal relationships and social support, while the environmental domain includes financial resources, safety, access to health and social services, living environment, opportunities for acquiring skills and knowledge, recreation and leisure, and transportation.

Data Collection Procedure

Data collection was conducted during the health outreach programme. Following informed consent, trained research assistants administered the study questionnaire and standardized assessment instruments to eligible participants through face-to-face interviews. The interview format was used to facilitate participation among older adults who might have difficulty completing self-administered questionnaires. Completed questionnaires were checked immediately after each interview for missing or unclear responses.

Ethical Considerations

Ethical approval

was obtained from the University of Nigeria Health Research Ethics Committee before commencement of the study. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. All participants provided informed consent before taking part in the study. Participation was voluntary, and participants were informed that they could decline participation or withdraw from the study at any stage without penalty. Confidentiality was maintained throughout the study by using identification codes rather than participants' names or other direct identifiers.

Statistical Analysis

Data was analysed using appropriate descriptive and inferential statistical procedures. Descriptive statistics were used to summarize participants' sociodemographic characteristics and study variables. Categorical variables were presented as frequencies and percentages, while continuous variables were

summarized using means and standard deviations. The distribution of continuous variables was assessed to guide the selection of appropriate inferential tests.

Spearman's rank-order correlation was used to examine the relationships between Perception of Ageing scores and the domains and total score of the WHOQOL-BREF. Differences in Perception of Ageing and quality-of-life scores across categories of functional ability were assessed using the Kruskal–Wallis test, with mean ranks reported for the respective functional-ability categories. Where the Kruskal–Wallis test indicated a statistically significant difference, post-hoc pairwise comparisons were performed using Bonferroni adjustment to identify differences between specific functional-ability categories. Statistical significance was set at $p < 0.05$.

Results

Socio-Demographic Characteristics of Participants (Table 1)

A total of 119 older adults aged 60 years and above were included in the analysis. The mean age of the participants was 67.08 ± 8.41 years. Females constituted 58.0% of the sample, while males accounted for 42.0%. Most participants were married (70.6%), while 18.5% were widowed, 5.9% were single, and 5.0% were divorced. Regarding employment status, 52.9% were self-employed, 15.1% were employed, and 31.9% were unemployed. Most participants were Christians (99.2%). Regarding lifestyle behaviours, 89.1% reported no history of smoking, while 31.1% reported alcohol consumption.

Table 1
Summary of socio-demographic characteristics

S/N	Variables	Class	M(SD)	Frequency	Percentage
1.	Age		67.084(8.406)		
2.	Gender	Male		50	42.0
		Female		69	58.0
3.	Marital status	Single		7	5.9
		Married		84	70.6
		Divorced		6	5.0
		Widowed		22	18.5
4.	Alcohol consumption	Yes		37	31.1
		No		82	68.9
5.	Employment status	Unemployed		38	31.9
		Employed		18	15.1
		Self-employed		63	52.9
6.	Religion	Christianity		118	99.2
		Others		1	0.8
7.	Smoking history	Yes		13	10.9
		No		106	89.1
Key: NFE = No Formal Education. SD=Standard Deviation					

Perception of Ageing among Participants (Table 2)

Table 2 presents the descriptive statistics for the domains and total score of the Perception of Ageing questionnaire. Among the individual domains, the Consequence Positive domain had the highest mean score (4.03 ± 0.69), followed by the Control Positive domain (3.80 ± 0.82) and the Timeline Chronic domain (3.39 ± 1.07). The Emotional Representation domain had a mean score of 2.83 ± 1.14 , while the Consequence and Control Negative domain had a mean score of 2.92 ± 0.96 . The overall mean Perception of Ageing score was 16.96 ± 2.32 .

Table 2
Descriptive analysis of the Perception of Aging domains and the total score of the Perception of Aging using mean and standard deviation

Variables	Mean $\pm$ SD
Timeline chronic	3.3866 $\pm$ 1.07443
Consequence positive	4.0252 $\pm$ 0.69456
Emotional representation	2.8319 $\pm$ 1.13734
Consequence and Control Negative	2.9160 $\pm$ 0.96181
Control Positive	3.7983 $\pm$ 0.81905
Perception of Aging Total score	16.9580 $\pm$ 2.31573
Key: SD=Standard deviation	

Functional Ability among Participants (Table 3)

Assessment of functional ability using the Global Activity Limitation Index (GALI) showed that 49.6% of participants experienced some degree of activity limitation. Specifically, 45.4% were limited but not severely, while 4.2% were severely limited. Conversely, 50.4% reported no activity limitation.

Table 3
Descriptive distribution of functional ability among participants (N = 119)

Measure	Category	Frequency	Percentage
Activity Limitation	Severely limited	5	4.2
	Limited but not severely	54	45.4
	Not limited	60	50.4
	Total	119	100.0

Quality of Life among Participants (Table 4)

Table 4 presents the descriptive statistics for the four domains and total score of the WHOQOL-BREF. The Social Relations domain had the highest mean score (65.17 $\pm$ 16.75), followed by the Psychological Health domain (60.53 $\pm$ 14.26) and Physical Health domain (60.25 $\pm$ 11.97). The Environment domain had the lowest mean score (53.65 $\pm$ 15.35). The overall mean WHOQOL-BREF total score was 239.60 $\pm$ 44.25.

Table 4
Descriptive analysis of the WHOQoLBREF domains and the WHOQoLBREF Total Score using mean and standard deviation

Variables	Mean $\pm$ SD
Physical Health	60.2521 $\pm$ 11.97258
Psychological Health	60.5294 $\pm$ 14.26494
Social Relations	65.1681 $\pm$ 16.75411
Environment	53.6471 $\pm$ 15.35103
WHQoLBref Total score	239.5966 $\pm$ 44.25127
Key: SD=Standard deviation	

Relationship between Perception of Ageing and Quality of Life (Table 5)

Spearman's rank-order correlation was used to examine the relationship between the total Perception of Ageing score and the WHOQOL-BREF domains and total score. No statistically significant correlation was observed between Perception of Ageing total score and Physical Health ($\rho = -0.106$, $p = 0.252$), Psychological Health ($\rho = -0.056$, $p = 0.548$), Social Relations ($\rho = -0.075$, $p = 0.419$), Environment ($\rho = -0.016$, $p = 0.862$), or WHOQOL-BREF total score ($\rho = -0.101$, $p = 0.273$).

Table 5
Results of Spearman's correlation between Perception of Ageing Total Score and each of the domains of WHOQoLBref and WHOQoLBref Total score

S/N	Measures	Rho	p-value
1	Physical Health	-0.106	0.252
2	Psychological Health	-0.056	0.548
3	Social Relations	-0.075	0.419
4	Environment	-0.016	0.862
5	WHQoLBref Total score	-0.101	0.273
Key: ρ = spearman's correlation value; p = significance value of the association			

Differences in Perception of Ageing and Quality of Life Across Functional-Ability Categories (Table 6)

Differences in Perception of Ageing and quality-of-life scores across functional-ability categories were assessed using the Kruskal–Wallis test. Perception of Ageing scores differed significantly across the three functional-ability categories ($\chi^2 = 8.177$, $p = 0.017$). The mean ranks were shown in Table 6.

Bonferroni-adjusted post-hoc comparisons revealed a significant difference between participants with no activity limitation and those with activity limitation that was not severe (adjusted $p = 0.038$). No significant differences were observed between the severely limited and no-limitation groups (adjusted $p = 1.000$) or between the severely limited and limited-but-not-severe groups (adjusted $p = 0.174$).

In contrast, WHOQOL-BREF total scores did not differ significantly across functional-ability categories ($\chi^2 = 2.708, p = 0.258$). Similarly, no significant differences were observed across functional-ability categories for Physical ($\chi^2 = 3.222, p = 0.200$), Psychological ($\chi^2 = 4.287, p = 0.117$), Social Relations ($\chi^2 = 2.997, p = 0.223$), or Environment ($\chi^2 = 0.118, p = 0.943$).

Table 6

Kruskal–Wallis Test of Differences in Perception of Ageing and Quality of Life Across Functional-Ability Categories

Measure	Not limited	Limited but not severely	Severely limited	χ^2	p
Physical Health	64.22	57.28	38.80	3.222	0.200
Psychological Health	66.25	53.07	59.80	4.287	0.117
Social Relations	63.69	57.92	38.20	2.997	0.223
Environment	60.82	58.87	62.40	0.118	0.943
Quality of life Total score	64.85	55.83	46.80	2.708	0.258
Perception of Ageing Total score	53.37	69.31	39.10	8.177	0.017
Key: χ^2 = Kruskal wallis H test value; p = significance value of the association					

Discussion

This study examined perceptions of ageing, functional ability, and quality of life among community-dwelling older adults in Southeast Nigeria. Participants had relatively favourable perceptions in the positive-consequence domain of the Perception of Ageing questionnaire, while 49.6% experienced some degree of activity limitation. Social Relations had the highest WHOQOL-BREF score, whereas Environment had the lowest. Although Perception of Ageing scores differed significantly across functional-ability categories, neither Perception of Ageing nor functional ability was significantly associated with quality of life.

The relatively high score for positive consequences of ageing suggests that participants did not perceive later life solely in terms of decline and loss. This is consistent with the multidimensional nature of ageing perceptions described by Sexton et al. (2014), who demonstrated that perceptions of ageing include beliefs about both positive and negative consequences, personal control, and emotional responses. Evidence from longitudinal research further indicates that perceptions of ageing are not

static. Diehl et al. (2021), using data from 4,712 adults followed for up to 21 years, found increasing perceptions of physical and social losses with advancing age but also demonstrated that perceptions of ongoing development persisted into later life. Similarly, Warmoth et al. (2016), in a systematic review of 28 observational reports, found that perceptions of ageing were related to multiple domains of health and functioning, including physical performance, disability, self-rated health and quality of life. These findings support the interpretation of ageing perceptions as multidimensional rather than uniformly negative.

Almost half of the participants experienced some degree of activity limitation, although only 4.2% were severely limited. This finding is consistent with evidence that functional limitations are common among community-dwelling older adults. In Nigeria, Gureje et al. (2006) reported substantial functional disability among older adults and identified increasing age, female sex, chronic pain and poor self-rated health as important correlates. The present prevalence should, however, be interpreted cautiously because GALI-defined activity limitation is not directly equivalent to disability based on dependence in activities of daily living. The finding nevertheless indicates that limitations in usual activities may be present even among older adults who remain largely independent in basic daily activities.

An important finding was the significant difference in Perception of Ageing across functional-ability categories. The highest mean rank was observed among participants who were limited but not severely, whereas the severely limited group had the lowest mean rank. The significant difference occurred between the no-limitation and limited-but-not-severely-limited groups, while comparisons involving the severely limited group were not significant. This pattern does not support a simple linear relationship between increasing limitation and increasingly negative perceptions of ageing. Nevertheless, previous evidence provides a plausible basis for an association between ageing perceptions and functional health. Levy et al. (2002), in an 18-year longitudinal study, found that individuals with more positive self-perceptions of ageing subsequently demonstrated better functional health after adjustment for baseline health and sociodemographic factors. Similarly, Tully-Wilson et al. (2021), in a systematic review of 21 longitudinal studies, reported consistent associations between more positive self-perceptions of ageing and healthier outcomes, including better activities of daily living, self-rated health and psychological outcomes. In a systematic review of observational studies, Warmoth et al. (2016) also found relationships between ageing perceptions and disability and physical functioning. These findings support the presence of a relationship between ageing perceptions and functional experience, although the cross-sectional design of the present study prevents conclusions about directionality.

Contrary to much of the existing literature, no significant relationship was found between total Perception of Ageing scores and any WHOQOL-BREF domain or overall quality of life. Velaithan et al. (2024), synthesizing 32 observational studies, reported that positive perceptions of ageing were generally associated with better quality of life, physical functioning, psychological health and general well-being. Similarly, Korkmaz Aslan et al. (2019) found that dimensions of attitudes towards ageing predicted quality of life among 999 community-dwelling older adults in Turkey. Importantly, however, evidence from Africa is comparatively limited. Gumikiriza-Onoria et al. (2022), in a study of 380

community-dwelling older adults in Uganda using the B-APQ, examined the relationship between ageing perceptions and quality of life in another sub-Saharan African setting. The limited African evidence makes the present Nigerian findings valuable, particularly because cultural, socioeconomic and environmental circumstances may influence how perceptions of ageing translate into quality of life. The discrepancy between the present findings and much of the existing literature may also reflect differences in measurement instruments, population characteristics, sample size, and the multidimensional nature of quality of life.

The absence of a significant association between functional ability and quality of life also warrants consideration. Although Gureje et al. (2008) identified functional disability as an important determinant of quality of life among 2,152 older Nigerians, the present study used GALI to capture limitations in usual activities rather than dependence in specific activities of daily living. Levasseur et al. (2008) similarly found that quality of life differed according to activity level among community-dwelling older adults, but clinically important differences were particularly evident between those without limitations and those with moderate-to-severe limitations. This observation is relevant to the present study because most participants with limitations were classified as limited but not severely. Thus, relatively mild or moderate activity limitations may not necessarily translate into substantial reductions in perceived quality of life.

The pattern of WHOQOL-BREF scores further emphasizes the multidimensional nature of quality of life. Social Relations had the highest score, whereas Environment had the lowest. This pattern is compatible with findings from the Ibadan Study of Ageing, where social participation and support were important determinants of quality of life, while economic status was the most consistent predictor across the four WHOQOL-BREF domains (Gureje et al., 2008). Similarly, evidence from community-dwelling older adults in Nigeria indicates that neighbourhood and environmental characteristics can influence quality of life, particularly in relation to physical activity and opportunities for community participation. These findings suggest that quality of life among older adults cannot be adequately explained by individual perceptions or functional status alone; social relationships, economic circumstances, physical environments and opportunities for participation may also contribute substantially.

Generally, the findings indicate that perceptions of ageing and functional ability are related but that their relationship with quality of life may be more complex than expected. The significant variation in ageing perceptions across functional-ability categories supports the importance of considering psychological perceptions alongside physical functioning in healthy-ageing and rehabilitation programmes. However, the absence of a significant association with quality of life suggests that interventions should not focus on ageing perceptions in isolation. Community-based strategies should also address functional independence, social participation, economic circumstances, access to health services and supportive environments. Given the cross-sectional nature of the present study, longitudinal research in diverse Nigerian communities is needed to determine whether perceptions of ageing predict subsequent changes in functional ability and quality of life, or whether changes in health and functioning subsequently shape perceptions of ageing.

Conclusion

Approximately half of the community-dwelling Nigerian older adults in this study experienced some degree of activity limitation. Perception of ageing differed significantly across functional-ability categories, but neither perception of ageing nor functional ability was significantly associated with quality of life. These findings highlight the need for healthy-ageing interventions that address functional ability alongside older adults' perceptions of ageing, social participation, and environmental conditions.

Limitations

The cross-sectional design limits the ability to establish causal relationships between perception of ageing, functional ability, and quality of life. The study was conducted among a relatively small sample of community-dwelling older adults in one setting, which may limit the generalizability of the findings to other Nigerian populations. Some information was self-reported and may therefore be subject to recall or reporting bias. Additionally, the small number of participants in the severely limited category may have reduced the statistical power to detect differences involving this group. Finally, although Bonferroni-adjusted post-hoc comparisons were conducted following the significant Kruskal–Wallis test, the interpretation of subgroup differences should be made cautiously because of the small sample size and unequal distribution across functional-ability categories.

Policy and Practice Implications

Community-based healthy-ageing programmes should incorporate routine assessment of functional ability and perceptions of ageing among older adults. Interventions should promote physical activity, maintenance of functional independence, positive and realistic perceptions of ageing, social participation, and supportive living environments. Larger longitudinal studies involving diverse Nigerian communities are recommended to clarify the temporal relationships between perceptions of ageing, functional ability, and quality of life.

Declarations

Ethics Approval and Consent to Participate

The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki for research involving human participants. Ethical approval was obtained from the University of Nigeria Health Research Ethics Committee (Approval Number: NHREC/05/01/2008B-FWA00002458-1RB00002323). Written and/or verbal informed consent was obtained from all participants prior to data collection.

Consent for Publication

Not applicable.

Availability of Data and Materials

The datasets generated and analysed during the current study are available from the corresponding author upon reasonable request.

Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

O.E.J. conceived and designed the study, performed the statistical analysis, and drafted the initial manuscript.

OCA. conducted the literature review, collected the data, and managed the dataset.

U.C.I. supervised the study, provided critical revisions, and approved the final version of the manuscript.

I.I.J. contributed to data collection, literature review, and interpretation of results.

All authors read and approved the final manuscript.

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