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Table of Contents

Content	Page
Appraisal of the Perception on the Re-Emmergence of Physical Planning in Selected Areas of South-Western Nigeria ***Medayese, S.O., Agbola, S.B, Shaibu, S.I, Maikudi, M. and Yakatun, M.M***	1
Accessibility of the Aged to Urban Infrastructure and Services in Ibadan, Oyo State, Nigeria. ***Sulyman A.O., Odegbenro F. J., and Omotosho B.O.***	16
Mapping of Hydrothermal Alterations Zones for Mineral Exploration in Kokona Area of Nasarawa State, Nigeria ***Muhammed M., Obafemi S.I., Hassan A.B, and Odekunle M.O***	30
Perspectives on Cost Management Roles of Quantity Surveyors' in Mechanical and Electrical Services Projects ***Amuda-Yusuf, G., Adebiyi, R. T. and Olowa, Theophilus, O.O***	39
Assessment of the Functionality of Public Tap Water System in Oyo West Local Government, Oyo State, Nigeria ***Toyobo, A. E and Bako, B. O***	51
Morphological Response of Ginzo River to Urbanization in Katsina Metropolis, Nigeria. ***Iroye, K. A. and Aminu, K.***	67
Assessment of Strength of Association Between Climatic Parameters and Some Selected Crops in Funtua, Katsina State, Nigeria ***T.I. Yahaya, R. Abdulaziz, Mary O. Odekunle And M.A Emigilati***	78
Assessment of Shoreline Change, Along Ondo Coastline, Ondo State, Nigeria ***Adebola A.O., Oluwole M.S., Ibitoye M.O. and Adegboyega S.A.***	86
Comparative Study of Government Resettlement Housing Schemes and Traditional Housing Settlement Pattern in Abuja: The Case of Gbagyi People. ***Ayuba P.***	103
Assessment of Ramp Designs as Accesses in Public Buildings in Abuja, Nigeria ***Anunobi, A. I., Adedayo, O. F., Ayuba P., Oyetola, S. A., & Otijele, G. O.***	119
Agricultural Practices Vulnerability to Floods Among Communities Downstream of Kainji Dam, Nigeria ***Musa M., Suleiman Y.M and Emigilati, M. A.***	132
Evaluation of Safety Condition in Students' Hostel Accommodation at the Federal University of Technology Minna, Gidan Kwano Campus. ***Bajere, P. A.***	141

ACCESSIBILITY OF THE AGED TO URBAN INFRASTRUCTURE AND SERVICES IN IBADAN, OYO STATE, NIGERIA.

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Abstract
The ideal urban environment is meant to provide a place to work, live and relax without any fear of insecurity but where this is not happening it shows there is a need for immediate intervention. The paper examines the provision of urban infrastructure in developing countries especially in Ibadan North local government, Nigeria. A total of 193 elders participated in the study. This sample was carefully selected through the administration of questionnaires using stratified sampling method. A group of 8 elders were engaged in focus group discussion on preferred care and other environmental issues. Out of the four infrastructural facilities examined namely: health, recreation, religious and shopping facilities, the study revealed that recreation and health facilities which are mostly needed by the aged are considered inadequate in terms of availability, adequacy and accessibility. 66.3% of the respondents agreed that health facilities were available but not within their easy reach in terms of distance and cost while 59.1% claimed not to enjoy recreational facilities. The paper recommends, among others, that our roads should be well connected with the provision of walkways to separate pedestrians from vehicular movements to encourage trekking and other forms of mobility for the elderly.

Keywords: Accessibility, Aged, Infrastructure, Neglect, Recreation

Introduction

Cities of the world are increasing daily with a number of them becoming unsafe to live and work due to risks posed by environmental challenges such as climate change, terrorism, kidnappings and other evils. Mostly hit by these challenges are the aged and the vulnerable due to poverty, neglect and especially in developing world. Although it may have existed from antiquity, aged neglect as a phenomenon of universal applicability and importance is only recently being recognized. According to Wolf (1999) almost a quarter century had passed since elder abuse and neglect first became a matter of public concern although the issue had surface briefly in British medicals journals in the mid-1970s. The reason for this apparent delay in raising aged abuse matters to the level of public discussion is not farfetched. For a very long time, there were no globally accepted standards for elderly abuse. What was acceptable in one race, ethnic group or culture could be very antithetical in the other. For instance, every culture whether ethnic or widely practiced has its own form of aged (abuse) or omission (neglect). Which could be intentional or unintentional and of one or more types; physical, psychological or financial abuse. Neglect in planning is another form of abuse that results in unnecessary suffering, loss of human rights and decreased quality of life. Whether an act is labelled as abusive or neglectful may depend on its frequency, duration intensity, severity, consequences and cultural context. Efforts were made by the developed countries to treat aged neglect. The situation is different in cities of developing countries and this has resulted into cities becoming more unsafe for this category of people.

The common factor in defining elderly is chronological age in years but this varies from one place to another. The World Health Organization (WHO) uses 65 years as baseline for aging. For the purpose of this research, elderly or aged refers to the group of people of 65 years and above in age in accordance to the 1999 Nigerian government policy on the aged. Access to urban services and infrastructure – water, roads, drains, school, electricity, sewerage and others, are issues of great concern to the urban poor. These services and other physical and social amenities including housing and health care make cities livable and allow citizens to be productive. The aged, benefit more from public spaces (recreation), shopping and health care which were considered as indicators for this research due to their stage of life that is more of leisure than work. United Nations (UN) 2010 on sustainable urban Transport reveals that increasing motorization in urban areas has added to urban pollution, congestion, accidents and deaths of more aged raising safety concerns. Those in their domestic setting are not exempted as they experience low degree of housing and environmental qualities. The situation is aggravated by the socio-cultural circumstances, rural-urban migration, family disorganization and neglect on the part of urban planners who are meant to design and develop the environment to meet the safety and comfort needs of all categories of people. Among the problems confronting the elderly in developing countries including Nigeria are poor living conditions, lack of recreation facilities, transport and medical services. Aside from this, where these facilities are available, the aged lack accessibility to them due to distance and mobility problem. According to Bolade 1993, the mobility problem is in the form of gross inadequacies of public transport, overcrowded buses, poor road infrastructure and absence of integrated traffic management measures. Providing the facilities and services is an issue on one hand, accessibility problems on the other.

Recreation is also usually difficult to be engaged in due to non-availability of community-based recreational facilities. They are therefore left in solitude. The aged suffer from impairments that can temporarily or permanently interfere with autonomous function face, a higher than average risk of degradation. Agboola (2002) observed that the depression, which they pass through as a result, is better imagined than experienced. According to the United Nations (2002) in too many countries, the aged are neglected even if still productive and have few health means or provision to live properly. The observance of a day for the elderly was instituted by the United Nations (UN) General Assembly in its resolution 45/106 of 14th December 1990. The poor living state of their housing units in form of absence of ancillary facilities and where available are made of slippery surfaces which contribute to immobility and fear. There is however, a danger of overlooking the greatest commonality among older people and their individuality. It is necessary to realise that not all persons who are elderly are vulnerable and inactive. Safe and not only urbanized cities can help maintain the aged in independent living situations in their homes and communities. The UN regarded the year 1999 as the International year of older persons UN, 1998). Out of the 62 recommendations by the UN for actions, recommendation no 56 emphasized researches into the developmental and humanitarian aspects of aging including health and social services for the aged. This calls for the participation of stakeholders in the built environment in aged neglect researches to provide a safe and satisfying urban environment. It is against this background that this paper assesses the neglect of the elderly in the provision of urban infrastructure and

services with a view to facilitating planning interventions.

Literature Review

Planning is a function of collective actions to better the environment. It is of three largely related aspects which are social, economic and physical, which cannot be effective without taking into account all these aspects. Planning involves regulatory measures on the basis of zoning of land use which were intended to protect environmental standards but planning has seemed to overlook the social and economic side effects which may be worse in some cases than the environmental effects of say mixed land uses would have been. The spatial distribution of facilities and services do not respond to the preferences of those who are most affected by them in terms of location and needs Adeniji-Soji (2000).

Communal facilities (CFs) as explained by Fakere &Ayeni (2013) differ from one community to the other depending on the size and what is needed within certain residential neighbourhood. The importance of CFs within the residential neighbourhood cannot be overemphasised. Apart from meeting several needs, it helps to reduce the need to travel for residents within such neighbourhoods where they exist. As such there is need for CFs to be an integral part of developments. Montgomery (2005, cited in Fakere & Ayeni 2013), observed that on a daily basis, people need places to meet as well as things to do when not at work, as such CFs provide the opportunity for inter relationship as well as bonding between residents of the same community. Gesler and Curtis (2006) cited in Fakere & Ayeni (2013) argued that the presence of CFs helps people to be attached to their locality as well as presents the opportunities of meeting with other people.

The United Nations observed in 2002 that large parts of the developing world are turning into ageing societies without social services to cope. According to the National Population Commission, 5% of the Nigerian population is aged and as observed by Asiyanbola (2005) the proportion of aged population has been increasing due to improved health services (See table 1).Other facilities and services in terms of recreation, religious and shopping are provided without walkways, vehicular movements are not separated from pedestrians' movements thereby affecting mobility of the aged.

Table 1: Increasing Aged group

Age group 1963 population census				1991 population census		
Years	Male	Female	Total	Male	Female	Total
60-64	447, 000	339, 000	786, 000	898, 801	791,573	1, 690, 374
65-69	162, 000	111, 000	273, 000	408,540	387,400	703, 040
70-74	182, 000	132, 000	314,000	492,186	394,116	886, 302
>75	331, 000	233, 000	564, 000	684,099	573,399	1, 257, 498
Total	20,882, 000	1,535,000	3,617,000	4,510,651	3,810,031	8, 227, 782

Source: Adapted from Asiyanbola R. Abidemi, 2005

While considering the pattern of life of the elderly in Ibadan, Asiyanbola (2005) used cooking, household shopping, fetching water and social activities in form of going to recreational centres as indicators. He found that more men 16.7% and only 2.0% women are found to be involved in recreation and average of 9.0 goes out recreation centres. This is the more reason why community –based support services is an important concept in attending to the aged. Community Based Support Services are usually carried out within the local settings. They provide assistance in residence or accessible locations such as community centres. The US government accounting office reported that individuals receiving expanded community –based services lived longer than those who did not (Social work, 1985).

The Nigerian Government set up an inter-ministerial committee on ageing due to the growing exposure of the pitiable condition of older citizens and growing global awareness (created particularly in the context of the designated 'International Year of the Older persons in 1999) of a policy for the elderly. Ojesina (2000) observed that the national policy is rooted in the additional respect for a high regard in which they are usually held. According to him, the main objectives of the policy are: to guarantee an improvement in the quality of life of the elderly in Nigeria, ensure his total integration in the society, provide adequate income security and strengthen existing traditional institutions for the care of the elderly. The specific objectives are to make available to every Nigerian adequate physical and mental health facilities for the elderly; ensure the provision of adequate recreational facilities for the elderly and enhance intergenerational interaction and co-operation; de-emphasise the use of old people's homes emphasizing community-based support system using the instruments of government.

Functions of the three levels of government are involved in The Federal Government shall be responsible for formulation and periodic review of national policy and legislation on the elderly, planning and other activities necessary for the effective implementation of national policy on aging. The state Government among others shall be responsible for: formulation and implementation of state programmes for the elderly; while local Government shall be responsible for among others: co-ordination of activities for the care of the elderly at the local government level; establishment of day facilities for the elderly; provision of adequate medical facilities for the elderly; provision of recreational facilities for the elderly; promotion of community-based care for the lonely elderly and collection of data and statistics on the situation of the elderly.

Study Area

There is only one overall municipal governance structure in Ibadan, Oyo State, Nigeria(see figures 1 &2) until August 1991 when the present eleven local government of Ibadan came into existence. Ibadan North Local Government (IBNLG) is one of these local governments in Oyo state. IBNLG was created on the 27th day of August 1991. It is the largest LG in Ibadan with a total land use of 145.58km2 which is approximately 4.66% of the total land area of Ibadan city. It is also the most populous with a population of 399,603 inhabitants, the majority (two-third) of whom are engaged in trading. The administrative headquarters is in Agodi, which is one of the major commercial centres in Ibadan land. The LG is classified into three with varying population density namely: Unplanned high density, planned high density and planned low density area. It has a total of 42.27km of roads of various categories including a dual carriage way. Except for the highly unplanned area which is not

served by roads, other parts have roads that are generally narrow and full of bends. The LG has 12 public health facilities located in various parts of the LG consisting of a Federal teaching hospital, University College Teaching Hospital (UCH); a state maternity hospital: and several primary and private health care centres. It has an amusement at Samanda and Agodi gardens. Several kinds of religious facilities owned by both private and community bodies are within the LG. Shopping Activities occur daily or weekly in their stores, supermarkets and market while grocery shops provide daily shopping.

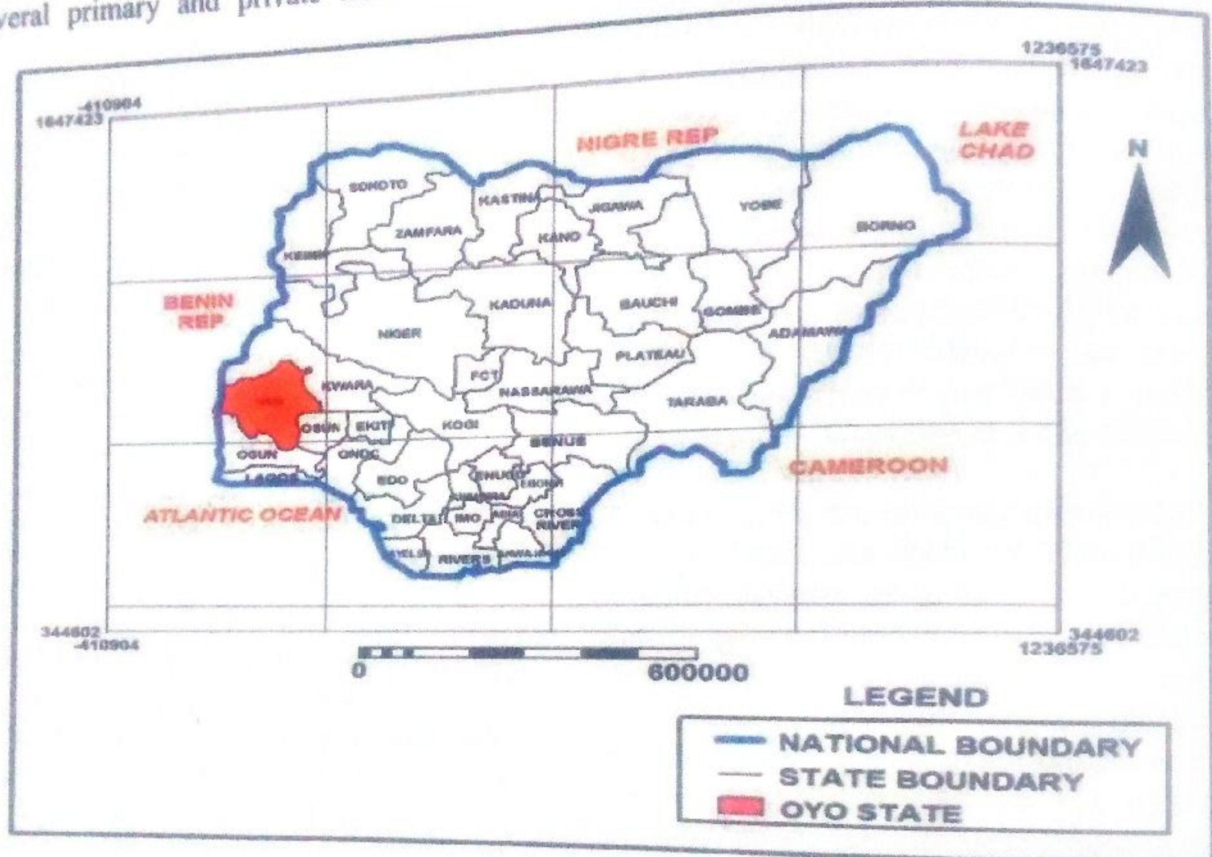

Figure 1: Map of Nigeria showing Oyo State

Figure 2: Ibadan North Local Government area.
Source: Town Planning Division, Ibadan North Local Government (2012)

Research Methodology

The study generated information from both secondary and primary sources. The primary data were acquired with the use of questionnaire and interview guide on socio-economic characteristics of the aged, their health condition and distribution of neighbourhood facilities. The sampling population for the study was 9654. These are the elderly of 65years and above. A convenient 2% sample size totalling 193 participated in the study. The local government authority segregated the population into significantly homogenous subgroups or strata namely: core unplanned (high density area), newly developed (high density area and newly developed (low density area). Stratified sampling technique was employed in the questionnaire administration to ensure adequate representation of the sample as no particular sub-group dominated the other. 87 questionnaires were administered in the core unplanned high density area having wards 1,2,3,4,6 and 8; 77 questionnaires went to newly developed high area comprising of wards 5,7,9,11 and 12 while 29 questionnaires were administered in the newly developed area having only ward 10 (See table 2). Some randomly selected elderly were engaged in a focus group discussion for more qualitative information. The data obtained were analyzed and hereby presented using descriptive methods. The secondary data used on rainfall and temperature pattern was from Nigerian Metrological Agency (NIMET) and on similar studies were from books and journals.

Table 2: Ward distribution of Ibadan North

Ward Number	Ward Name
1	Beere, Agbadagbudu, Oke-Are
2	Ode-Olo, Inalende, Oniyanrin
3	Adeoyo, Yemetu, Oke-Aremo
4	Itutaba, Oje-Igosun, ali-Iwo, Total Garden
5	Basorun, Ashi, Gate
6	Sabo Area
7	Oke-Itunu, Coca-Cola, Oremeji
8	Sango
9	Mokola
10	Old and New Bodija
11	Samonda, The Polytechnic and UI
12	Agbowo, Bodija Oja, Bodija Ojurin

Source: Ibadan North Local Authority, 2012

Results and Discussion

Socio-Economic Characteristics of Respondents

Gender of Respondents

The study recorded, as displayed in table 3, highest frequency from male accounting for 58.5% of the respondents while female respondents were 41.5% as revealed in table 3. The percentage of male being more than female could be implied that life expectancy rate differs.

Table 3: Sex of Respondents

Sex	Frequency	Percentage
Male	113	58.5
Female	80	41.5
Total	193	100.0

Source: Authors' Field work, 2012

Age Distribution of Respondents

It was observed as shown in table 4, that the majority (74. 6%) of the respondents were between ages 65-69 years, 12.4% belonged to ages 70-74 years, and 6.7% were 80-84 years. The group of respondents between ages 75-79 were 5.2% while the respondents above 85 years were only 1% showing the low life expectancy rate and the study area giving a considerable number of the aged for assessment.

Table 4: Age of Respondents

Age	Frequency	Percentage
65-69	144	74.4
70-74	24	12.4
75-79	10	5.2
80-84	13	6.7
85 and	2	1.0
Total	193	100.0

Source: Authors' Field work, 2012.

Educational Level of Respondents

The level of educational attainment of the respondents as shown in table 5 below were: post-secondary education had 18.1%, secondary had 47.2%, primary (standard 6) had19.2% while those with no formal education had 15. 5%. This revealed that education is appreciated among the people and they are enlightened.

Table 5: Educational Level of Respondents

Educational Level	Frequency	Percentage
No formal education	30	15.5
Primary/Standard 6	37	19.2
Secondary	91	47.2
Post-Secondary	35	18.1
Total	193	100.0

Source: Authors' Field work, 2012.

Occupation of Respondents

A study on the occupation of the aged to determine their pattern of income showed that 39.4% engaged in trading, 6.2% in farming, 9.3% were in the civil service, 11.9% worked with private firm and 42.5% were retirees. For the retirees, the majority (35.3%) retired from the civil service, 3.6% retired from service industry, and trading accounted for 3.6% ((see figure 3).

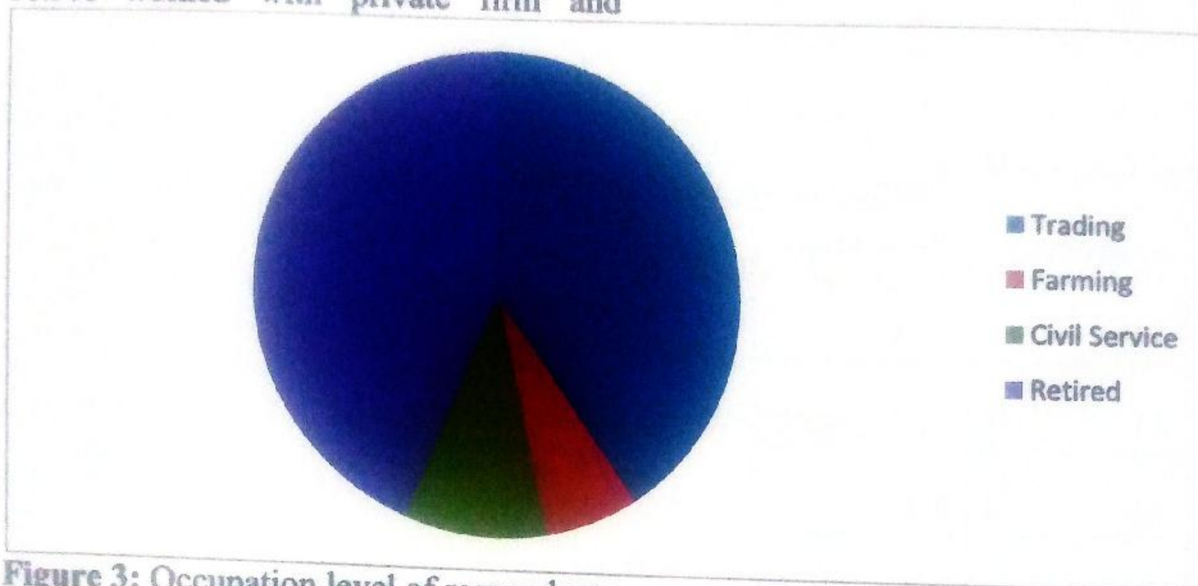

Figure 3: Occupation level of respondents
Source: Authors' Fieldwork, 2012

Income Sources of Respondents

Further information on their income pattern signifies that 48.7% of them earned only from their engagements, 20.3% earned from their children and 22.4% from pensions while 5.7% comes from past investments (see figure 4). This income level indicates that the aged still earns with the majority coming from their daily engagements. This is however not surprising but affirming the fact that not all elderly are inactive and if so, the environment has to be made liveable.

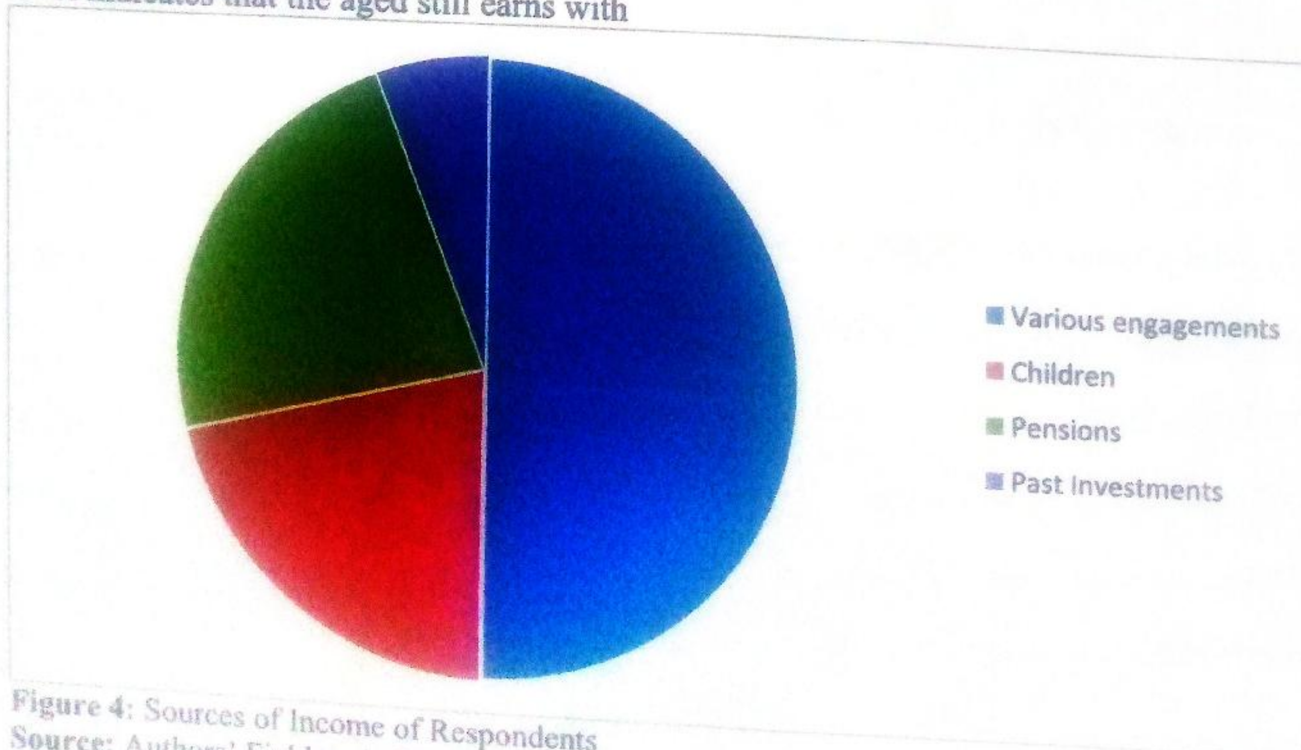

Figure 4: Sources of Income of Respondents
Source: Authors' Fieldwork, 2012.

Health Condition of Respondents

Old age is not altogether a boring and frustrating segment of life. This assertion was confirmed by the result of the aged on health condition in which 20.7% of them had health condition that was assessed to be excellent, 58.5% had health condition that was good. 14.5% of the respondents had health condition that was assessed to be fair while the remaining 14.5% regarded their health as poor (table 6). This implies that the majority of them are still full of life and vigour enough to take on extra job after retirement thereby making them to be an important stakeholder in neighbourhood planning related matters.

Table 6: Health Condition of Respondents

Description	Frequency	Percentage
Excellent	40	20.7
Good	113	58.5
Fair	28	14.5
Poor	6	3.1
Very Poor	6	3.1
Total	193	100.0

Source: Authors' Fieldwork, 2012

Distribution of Facilities and Services

The study considered four essential facilities that could improve the living standard of the aged in any environment, namely: health, recreational, religious and shopping. These facilities were examined in terms of their availability, accessibility and adequacy.

Availability of Facilities and Services

The availability of these facilities is a determinant of other factors considered in the distribution of facilities and services. 66.3% of the respondents claimed that health services were available while 33.7% did not have health services. 40.95% of the respondents enjoyed recreational facilities while 59.1% did not have recreational facilities. A large number of the respondents (89.1%) enjoyed religious services with while only 10.8% did not enjoy it and shopping facilities were enjoyed by 69.4% while 30.6% did not enjoy shopping facilities as shown in figure 5.

Most of these facilities that were claimed to be enjoyed by the respondents were available within their neighbourhoods while the ones not enjoyed were not readily available due to lack of these facilities within their neighbourhoods on one hand and the long distance to be covered to where they are available on the other. Recreation which is majorly what the stage of life of the elderly and aged is about was lacking in the study area especially the areas designated as the unplanned high area and unplanned low areas of the study area while those that

claim to enjoy did so in their private homes or in front of their houses with games like Draught, local Ayo, Ludo and Chess which is basically within the planned low area.

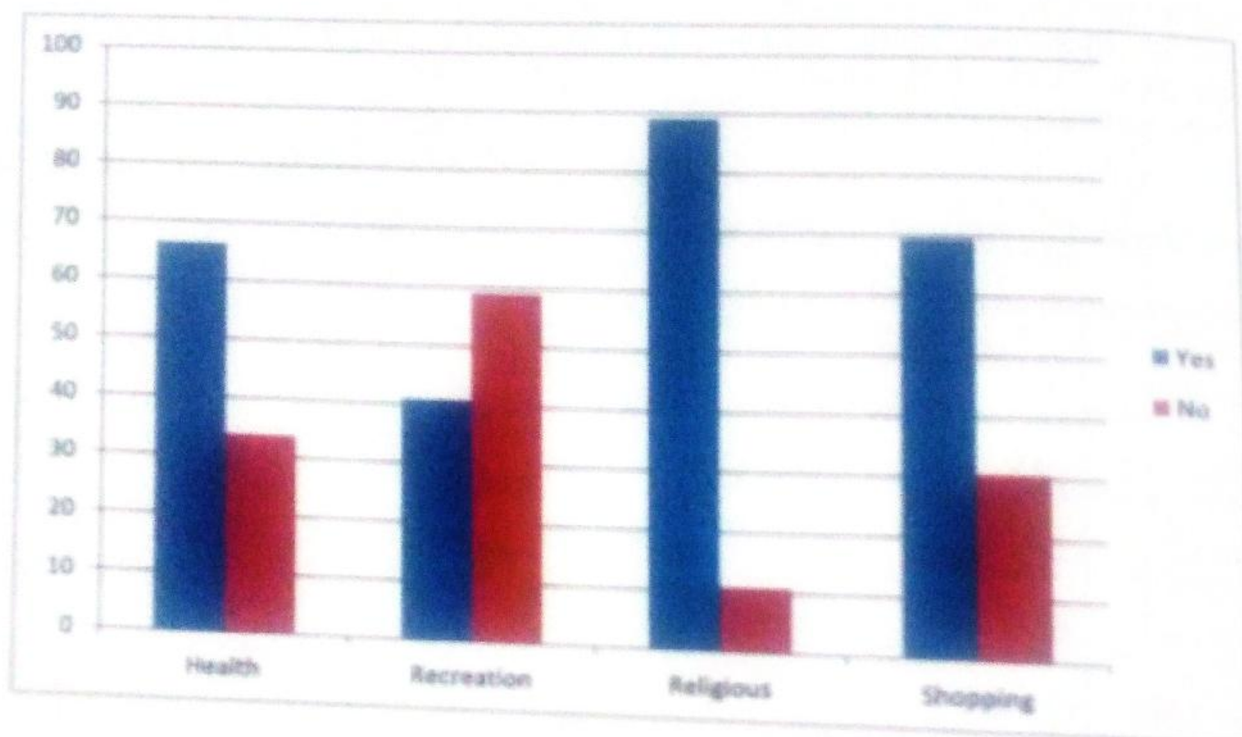

Figure 5: Availability of facilities and services
Source: Authors' Fieldwork, 2012

Adequacy of Facilities
In considering how adequate the facilities are, majority of 44.0% agreed that the health facilities were averagely enough because they were found to be available even though not within easy reach. Recreational facilities were reported to be highly inadequate by 59.65% of the respondents. 57.5% of the respondents considered religious facilities to be very adequate in meeting their needs while 40.4% were of the opinion that shopping facilities are averagely adequate because the two facilities exist within their neighbourhoods. This again implies that the major requirement of the elderly which is a life of leisure more than work is still far from being achieved.

Accessibility to Facilities and Services
In assessing the accessibility of the elderly to urban facilities and services, distances and mode of transport were considered. The study revealed, as shown in table 6, that the respondents had shopping and religious facilities within reach while health and recreational facilities which are most needed were not easily accessible due to distance and cost. 43.6% of the respondents had their health facilities located above the distance of 1km while 31.6% of the respondents had their health facilities located below 500km, 24.8% had it located between 500m and 1km. The majority of the respondents (48.2%) reported to the distance covered to enjoy recreational facilities was above 1km. 25.9% had it between 500m and 1km while the remaining 25.9% had below

500m. In the case of religious centres, the study shows that majority of aged of 61.1% enjoyed religious activities which they had located below 500m and only 13.4% had it located above 1km. The planning standards recommended for a neighbourhood park, shopping, place of worship and health facilities are maximum service radius between 400-800km. This pattern of responses revealed clearly that in spite of the availability of these facilities, recreation facilities could not be easily reached.

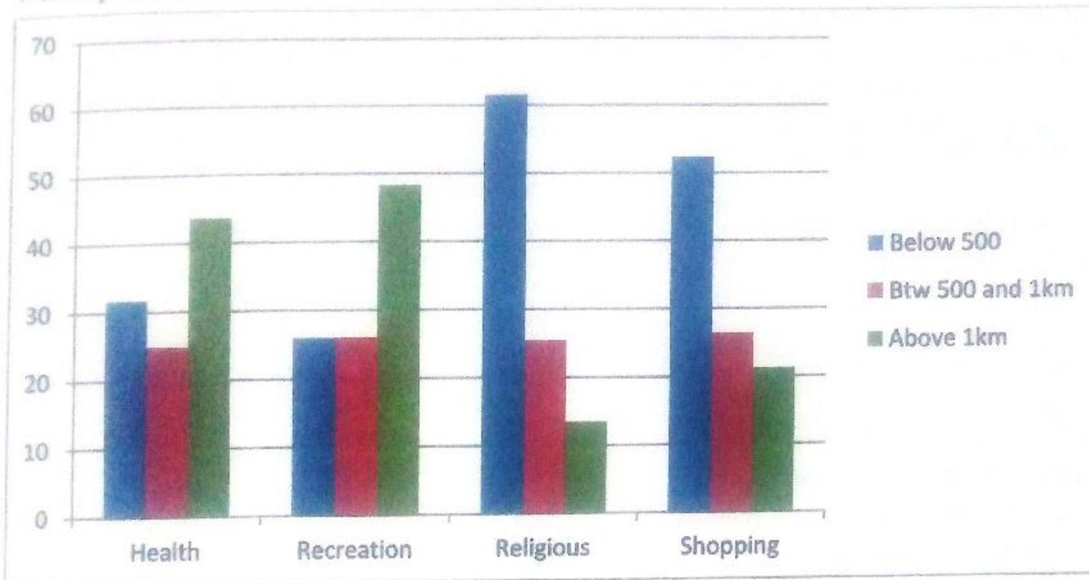

Figure 6: Accessibility of the elderly to facilities and services
Source: Authors' Fieldwork, 2012

Mode of Transportation

Considering the claimed distance of the facilities to the elderly, there arose the need to ask the mode of transport. 47.7% of the target group accessed the facilities through private cars, 26.9% accessed through public transport while the remaining 25.4% were engaged trekking as a mode of transportation. Out of the respondents that had trekking as a mode of transportation to these required facilities, 89.1% claimed there were difficulties in mobility; they reported fear of being knocked down by on-coming vehicles.

Availability of Walkways

The study revealed that walkways were only provided on major roads of the area within the study area designated as planned low density residential areas while other access roads in the remaining parts of the study area designated as planned high density and unplanned high density were provided with none. This invariably alluded to the fear expressed by the respondents on mobility.

Care Preference

In most developed countries, home for the aged is advocated and being used to provide appreciable care for the elderly. This was not the case with the elderly in developing countries as revealed by the study. The aged group considered home for the aged as no option to caring for them as they believed it would amount to house arrest thereby sending them to their early graves. The total of 83.9% of them preferred the environment where they had lived and adjusted to being adequately provided with necessary community facilities and services. Home care service was preferred by 10.4% and 5.7% opted for home for the aged as shown in table 7.

Table 7: Care Preference

Type of Care	Frequency	Percentage
Community Facilities	162	83.9
Home Care Service	20	10.4
Home for the Aged	11	5.7
Total	193	100

Source: Authors' Fieldwork, 2012

Conclusion and Recommendations

The research findings have implications on planning. Ageing of population is a desirable and natural desire of any society and it is an irreversible process once it starts. If ageing is to be an interesting experience however, it must be accompanied by improvements in the quality of life of those who have reached or approaching old age in our communities. Availability of urban facilities and services may contribute to environmental satisfaction but cannot substitute for accessibility and quality, which can be achieved through inclusive planning. Therefore, planning interventions should be participatory and all inclusive in order to accommodate this category of people in our highly urbanized environments.

With the identified problem of aged neglect in provision of urban facilities and services, it is expedient to recommend that:

i. The study recommends that these desirable facilities should be provided with the participation of the target group in the required quantity and location. Health and recreational facilities should be community based as they get more easily accessible by the elderly in terms of distance

ii. There should be interconnectedness of our roads with well-planned walkways to separate pedestrians from vehicular movements thereby encouraging trekking and other forms of mobility.

iii. Our new urban areas need to be developed with the people in the provision and distribution of facilities while the existing ones need to be upgraded to perform their functions of working, living and recreation.

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