

Effects of self-isolation policy on the psychosocial state (condition) of senior citizens in Nigeria, Pakistan and South Africa

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ABSTRACT

This study presents a cross-country comparison of the psychosocial effects of the COVID-19 self-isolation policy (SIP) on senior citizens in Nigeria, Pakistan, and South Africa. Specifically, it examines seniors' perceptions of self-isolation and its impact on their health, social interactions, attitudes, behaviours, and psychological well-being. A cross-sectional comparative design was employed using an online questionnaire adapted from Hughes' (2004) short-scale loneliness measure. Data were collected between June 6 and August 3, 2020, via social media platforms (WhatsApp, Facebook, Skype), with a total of 350 respondents selected through a multistage sampling procedure. Descriptive statistics and Analysis of Variance (ANOVA) were used for analysis. Results revealed that SIP was perceived as detrimental to seniors' health. The mean scores for Nigeria = 3.10; Pakistan = 3.08; South Africa = 3.05, causing anxiety, sleep disturbances, $\bar{x}$ = 3.37, 3.15, 3.64, reduced physical activity and social participation, $\bar{x}$ = 3.08, 3.18, 3.44, and negatively affecting mental and emotional well-being, $\bar{x}$ = 3.02, 3.05, 3.16. Fear of death was more pronounced in Pakistan, $\bar{x}$ = 3.53, and South Africa, $\bar{x}$ = 3.44, while loneliness was more reported in Nigeria, $\bar{x}$ = 3.08 and South Africa. Significant differences emerged across countries in experiences of fear ($F = 15.350$, $p < .001$), anxiety ($F = 6.265$, $p = .014$), and general psychosocial outcomes ($p < .01$), underscoring the influence of cultural, social, and policy contexts. The findings suggest the urgent need for culturally responsive mental health and social support strategies for elderly populations during public health emergencies.

Keywords: Attitude, COVID-19, Emotion, Perception, Response, Self-isolation

INTRODUCTION

The global spread of COVID-19 had enormous consequences on health, lives, livelihoods, and the well-being of people worldwide (OECD, 2020; Cascella *et al.*, 2023). By May 2020, the COVID-19 pandemic had impacted 216 countries, resulting in a significant global mortality burden. While the acute phase of the pandemic has subsided in many regions, its lingering effects continue to be felt, with ongoing challenges in public health, economic recovery, and social equity. The effects of the COVID-19 pandemic on the global population are severe. Senior citizens/older adults (65 years and older) (Wong *et al.*, 2023) and people with underlying ailments are at greater risk if contracted due to the physiological changes accompanying ageing and potential underlying health conditions.

Consequently, public health authorities recommended prolonged self-isolation for elderly individuals to reduce their risk of infection and alleviate pressure on overburdened healthcare systems. Isolating the elderly may reduce transmission, which was necessary to delay the peak in cases and minimise the spread to high-risk groups (Centres for Disease Control and Prevention [CDC], 2020; World Health Organisation [WHO], 2020. However, scientific literature has documented the bidirectional and complex relationship between psychological issues and social

disconnectedness. Several researchers, like Kai *et al.* (2020), Santini *et al.* (2020), Seegert (2017), Klinenberg (2016), and Gerst-Emerson and Jayawardhana (2015), have shown that social isolation can lead to feelings of loneliness, fear, and/or negative self-esteem. These studies affirmed that social isolation among senior citizens has grave public health consequences due to their heightened risk of mental health problems, autoimmune, cardiovascular, and neurocognitive problems. Social isolation and loneliness were also positively correlated with mortality in the elderly population (Seegert, 2017). Thus, the feelings of loneliness might lead to the emergence of other diseases among senior citizens.

Also, one of the significant and effective factors for the physical and mental wellness of the elderly is social participation, a fundamental human right that could assist them in maintaining social order and improving their quality of life. The literature further suggests that feelings connected to and involved in social gatherings are important for mental and physical health. Moreover, social integration and support have protective effects on morbidity and mortality outcomes. Contrarily, social isolation is highlighted as a "growing health epidemic" among the elderly population (Seyfzadeh *et al.*, 2019; Seegert, 2017).

The COVID-19 pandemic exacerbated loneliness among the elderly by necessitating strict self-isolation

measures. There is no doubt that it will affect the psychosocial well-being of the seniors. Since the announcement of COVID-19, several studies have been carried out (Armitage and Nellums, 2020; Kai *et al.*, 2020; Santini *et al.*, 2020; Liu *et al.*, 2020; Yang *et al.*, 2020), with most of these giving general information on COVID-19, consequences, features, symptoms, prevention, and control in general and in China where the disease erupted. However, there is a dearth of information on the perceived effects of COVID-19 on the elderly's well-being across countries (Nigeria, Pakistan, and South Africa), hence, this study was to fill the gap in social welfare among old-age people in developing countries. Nigeria, Pakistan, and South Africa were deliberately selected for this study due to their shared characteristics as developing countries with similar socio-cultural dynamics, including strong family ties, community-centred living, and a high dependence of older adults on social networks for emotional and physical support. At the peak of the COVID-19 pandemic, these countries also faced comparable challenges such as fragile healthcare systems, limited social safety nets for the elderly, and stringent self-isolation measures that disrupted traditional caregiving structures. These commonalities made them suitable for a cross-country comparison of the psychosocial effects of the pandemic's isolation policies on senior citizens. Particularly, this article aimed to explore the socioeconomic characteristics of senior citizens and to find out the impact of self-isolation policies on senior citizens' psychology (attitude, behaviour, consciousness) in these countries.

METHODOLOGY

Nigeria is located in West Africa, bordered by Niger, Chad, Cameroon, and Benin, with maritime borders including Ghana and Equatorial Guinea. It comprises 36 states and the Federal Capital Territory (Abuja). With a population of about 236 million (Worldometer, 2025) and a land area of 910,770 km², Nigeria is religiously diverse and officially English-speaking. It has a mixed, emerging-market economy, ranked 27th globally by nominal GDP and 24th by purchasing power parity, with a GDP of USD 363.85 billion and 1.9% annual growth (World Bank, 2023).

Pakistan, in South Asia, is the fifth-most populous country with over 225 million people and an area of 881,913 km². Bordered by India, China, Afghanistan, and Iran, it has a coastline along the Arabian Sea. It comprises provinces like Punjab, Sindh, Khyber Pakhtunkhwa, Balochistan, and Gilgit Baltistan. The country has a semi-industrialized economy transitioning from agriculture to services (GoP, 2023).

South Africa, located at the southern tip of Africa, has a population of approximately 64.6 million

(Worldometer, 2025). Bordered by Namibia, Botswana, Zimbabwe, Mozambique, and Eswatini, it enjoys a temperate climate. With a diversified economy built on agriculture, mining, tourism, and services, South Africa has a GDP per capita of USD 13,687 and ranks 84th globally for ease of doing business (StatsSA, 2019).

All the senior citizens of the three countries (Nigeria, Pakistan, and South Africa), aged ranges from 60 years and above, constituted the population of the study. These people can be divided into three main groups: young-old (60-74 years), middle-old (75 to 84 years), and old-old (85 years and above) people.

A multistage purposive sampling procedure was employed for this study. The focus was on regions with a relatively higher concentration of literate elderly populations and significant exposure to the COVID-19 pandemic during the peak period.

Nigeria has six geopolitical zones: Northeast, North Central, Northwest, South-South, Southeast, and Southwest. The Southwest zone was purposively selected based on its higher literacy rates among senior citizens and better access to online communication platforms. Three states were randomly selected from the six states in the Southwest. Given data collection limitations and to ensure manageable fieldwork, an equal number of 50 senior citizens per state were sampled, totalling 150 respondents. While this approach was partly influenced by convenience, it ensured a balanced representation of urban and peri-urban elderly populations within the selected zone. The sampling frame was derived from local community associations and directories of senior citizens obtained through state Ministries of Health and Social Welfare.

In Pakistan, Sindh province was purposively chosen due to its high incidence of COVID-19 cases during the study period. Within Sindh, Karachi, Sukkur, Hyderabad, and Larkana were included based on the regional distribution of cases and accessibility. The sample distribution reflected the proportion of elderly COVID-19 patients across these cities: 90 from Karachi and 20 each from Sukkur, Hyderabad, and Larkana, resulting in 150 respondents. The sampling frame was obtained through collaboration with local health departments and elderly welfare organizations.

In South Africa, data were collected from Limpopo, Eastern Cape, and Northwest Province, chosen for their diverse socio-economic profiles and varying pandemic impacts. Initially, 50 senior citizens per province were targeted. However, due to low response rates and logistical challenges, the final sample included 20 respondents from Limpopo, and 15 each from Eastern Cape and Northwest Province, totalling

50 respondents. The sampling frame was based on lists provided by provincial Departments of Social Development and elderly care homes.

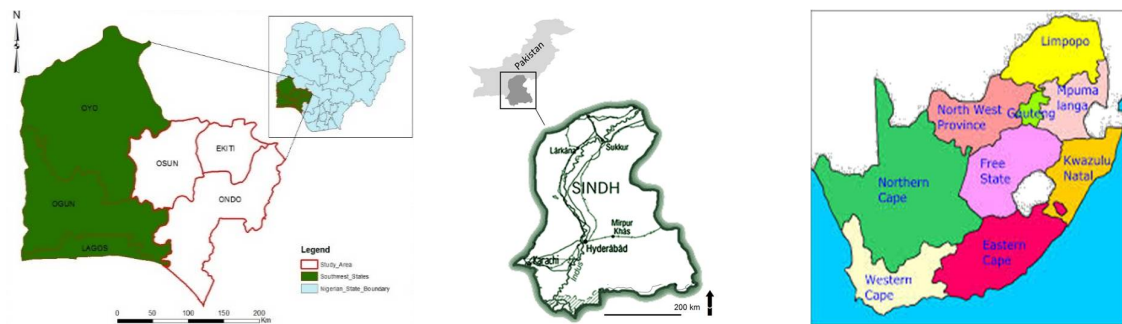
The use of a purposive multistage sampling approach was informed by the need to target regions with higher elderly population visibility, better internet accessibility, and significant COVID-19 exposure. While convenience influenced some selections, efforts were made to ensure that within these regions, the sample sizes reflected either proportional distributions (as in Pakistan) or operational feasibility (in Nigeria and South Africa). Incorporating official health and social welfare agencies for sampling frames added credibility and reliability to the respondent selection process.

The questionnaire was developed using an online survey tool (e.g., Google Forms) to facilitate data collection during the pandemic lockdowns. The survey link was shared directly with pre-identified

respondents through established social networks such as WhatsApp, Facebook, and email.

For Nigeria, the sampling frame was created in collaboration with state-level Ministries of Health and Social Welfare, elderly associations, and community-based organisations, which provided contact lists of literate senior citizens with internet access. Similarly, in Pakistan and South Africa, local health departments, elderly care homes, and welfare NGOs facilitated access to senior citizens by providing databases of potential respondents who met the study criteria.

These organisations also assisted in initial contact and follow-up reminders, ensuring the pre-identified elderly participants received the survey link and understood the study's purpose. Where necessary, family members or caregivers supported the seniors in completing the online questionnaire, ensuring inclusivity despite potential digital literacy barriers.



A: Study area from Nigeria

B: Study area from Pakistan

C: Study area from South Africa

Figure 1: Maps showing data collection regions of three countries.

The data for the study were collected through a detailed questionnaire. The questionnaire was developed following the short scale for measuring loneliness (Hughes, 2004) and social isolation among COVID-19 patients aged 60 and above by using multiple indicators (Cornwell and Waite, 2009). The instrument consists of open and closed-ended questions patterned after the study objectives. The questionnaire was developed with an online tool and disseminated through a link to the pre-identified respondents. The data collected were treated to acquire statistical inferences by using frequency, percentages, means, etc. the impact of SIP on psychosocial of senior citizen were measured on a five-point Likert-type scale (from Strongly Agree (SA) to Strongly Disagree (SD)) and Analysis of Variance (ANOVA) was used to show the difference(s) in the responses of the senior citizens to COVID-19 during their self-isolation across the study area.

RESULTS AND DISCUSSION

Socioeconomic characteristics

The results in Table 1 show that the mean age of senior citizens interviewed across Nigeria, Pakistan and South Africa were 66.2, 67.8 and 69.4 years, respectively, an indication that they were within the young old age group (Neugarten, 1974). More than half of the senior citizens from Nigeria (61.33 percent) and South Africa (58 percent) were female, while most of their counterparts from Pakistan were male. Most of the respondents from Nigeria practiced Christianity, while all the respondents interviewed in South Africa belonged to the Christian faith, and about 70.7 percent of respondents from Pakistan were Muslims. It could be said that although there were other religious practices in the three countries, the respondents were mainly within the Christian and Islamic religions. The marital status of the respondents shows that most of the respondents from Nigeria (60 percent) and

Pakistan (68 percent) were married with children, and only 34 percent of similar respondents were found from South Africa. Those elders who married but lived with others were about 22, 16.7, and 26 percent in Nigeria, Pakistan, and South Africa, respectively. The researchers found it concerning that a significant number of elderly individuals were not being cared for by their own children and were instead residing with non-relatives or in alternative living arrangements.

The average household size of respondents from Nigeria, Pakistan, and South Africa was 6.5, 8.2, and 6.0 persons, respectively. This suggests that senior citizens in Pakistan tend to live in relatively larger households, likely due to prevailing cultural norms and extended family structures that emphasize intergenerational cohabitation and familial caregiving responsibilities (Sathar & Kiani, 1998). According to Ataullahjan *et al.* (2022), large family sizes in developing countries like Pakistan form social capital for the family.

The results on educational attainment indicate that most senior citizens across the three countries had received one or more forms of formal education. Notably, a higher proportion of respondents from Nigeria (70.0%) and South Africa (50.0%) attained higher levels of education compared to their Pakistani counterparts (32.67%). This finding is consistent with

global education trends, where older adults in sub-Saharan Africa, particularly in countries like Nigeria and South Africa, tend to have higher literacy and educational levels than their counterparts in South Asia, such as Pakistan (UNESCO Institute for Statistics, 2019; National Population Commission [Nigeria] & ICF, 2019; Pakistan Bureau of Statistics, 2017).

The senior citizens cut across various occupations, although retired civil servants were higher among Nigerians (55.3 percent) and Pakistanis (44 percent). There were more traders (48 percent) among the South African senior citizens (48.0%) than among the Nigerian (12.0%) and Pakistani (16.0%) senior citizens. Also, the farmers were higher among the Nigerian respondents than in the two other countries. About 78 percent of the senior citizens in South Africa were still working even when they crossed retirement age and were involved in trade/business. The situation wasn't the same among the senior citizens in Nigeria and Pakistan. The results further show that more than 83 percent of the respondents lived within joint families or with guardians in all three countries. The strong family orientation commonly observed in developing countries often translates into close-knit household structures and shared caregiving responsibilities for elderly family members (Croll, 2006).

Table-1: Socio-economic characteristics of the respondents

Description		Unit	Nigeria (N=150)	Pakistan (N=150)	South Africa (N=50)
Average age		Years	66	68	69
Average family size		No.	6	8	6
Level of education	Adult Education	%	6.67	15.33	8.00
	Primary Education	%	12.00	17.33	24.00
	Secondary Education	%	11.33	34.67	18.00
	Tertiary Education	%	70.00	32.67	50.00
Gender	Male	%	48.67	70.67	44.00
	Female	%	51.33	29.33	56.00
Religion	Christianity	%	71.33	4.00	100.0
	Islam	%	22.00	85.33	0.00
	Others	%	6.67	10.67	0.00
Marital status	Married, alone	%	11.33	6.67	2.00
	Married, with children	%	60.00	68.00	34.00
	Married, but living with others	%	22.00	16.67	26.00
	Single, alone	%	3.33	3.33	14.00
	Single, with children	%	3.33	5.33	18.00
	Single, but living with others	%	0.00	0.00	6.00
Primary occupation	Farming	%	14.00	17.33	10.00
	Artisan	%	2.67	10.00	8.00
	Civil Servant (retired)	%	55.33	44.00	34.00
	Driving	%	4.00	8.00	0.00
	Hair Dressing	%	12.00	4.67	0.00
	Trading	%	12.00	16.00	48.00
Still working	Yes	%	46.0	43.33	78.0

Living in a joint family	%	83.33	86.00	92.00
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Source: Field survey, 2020.

Self-isolation and social networks

When considering Social Network Size and Psychosocial Well-being, the report in Table 2 shows that most of the elderly respondents in Nigeria (82.67%) and South Africa (76%) have very small social networks (1–4 people). Pakistan shows a relatively more diverse network size, 41.33% having 5–8 persons and 10.67% exceeding 12 persons. Berkman *et al.* (2000) emphasised that smaller social networks in older adults are associated with increased risks of depression, loneliness, and cognitive decline. The protective role of expansive networks is well documented. According to Cornwell & Waite (2009), older adults with limited social contacts experience more feelings of isolation and report lower life satisfaction. Litwin and Shiovitz-Ezra (2011) found that network diversity (not just size) significantly reduces loneliness and psychological distress among older adults. The larger and more diverse social networks observed in Pakistan may therefore serve as a psychosocial buffer during isolation.

Findings on the composition of social networks show that most seniors in South Africa (54%) and Nigeria (48%) depend on a broader network that includes children, relatives, and neighbours. Pakistan shows a higher proportion of seniors relying solely on children (24.67%) or friends and neighbours (18.67%), suggesting differences in cultural caregiving norms and support structures. In African settings, extended kinship structures play a critical role in elderly care

(Aboderin, 2004). Social connectedness with relatives and neighbours helps provide emotional and instrumental support during crises like pandemics. In Pakistan, Ali *et al.* (2020) observed that strong filial piety norms exist, but elderly care is increasingly shifting from extended to nuclear family systems, often isolating seniors in urban contexts. Harper (2014) emphasises that neighbourhood ties and proximity to kin are essential to mitigating the effects of isolation, particularly when digital communication options are limited.

In terms of the perception of neighbourhood safety, South African seniors reported the highest positive perception of neighbourhood safety (80% rate it as Good/Very Good/Excellent). In Nigeria, the majority also rate their neighbourhood as Good or Very Good (78.67%), though with fewer rating it as Excellent. Pakistan reflects concerns, with 34% rating neighbourhood safety as Poor. Stafford *et al.* (2007) found that perceived neighbourhood safety significantly influences the mental health of older people. Unsafe environments discourage outdoor activity and social contact, leading to increased isolation. In Pakistan, Khan *et al.* (2019) reported that elderly persons living in urban, low-income areas face more anxiety and depressive symptoms due to both isolation and insecurity. Cramm & Nieboer (2014) in South Africa highlighted that positive perceptions of neighbourhood safety were correlated with higher well-being and less loneliness among elderly populations.

Table 2. Percentage distribution of responses regarding social networking of the respondents

Questions		Nigeria (N=150)	Pakistan (N=150)	South Africa (N=50)
How many people are in your social network?	1 – 4	82.67	40.00	76.00
	5 – 8	16.00	41.33	22.00
	9 – 12	1.33	8.00	2.00
	More than 12	0.00	10.67	0.00
Who is in your social network?	Children only	6.67	24.67	14.00
	Children and relatives	38.00	18.00	22.00
	Children, relatives, and neighbours	48.00	34.00	54.00
	Friends and neighbours	5.33	18.67	4.00
	Members of religious bodies	2.00	4.67	6.00
How do you rate your neighbourhood safety status?	Excellent	2.00	4.00	12.00
	Very good	38.67	22.67	30.00
	Good	40.00	21.33	38.00
	Fair	17.33	18.00	14.00
	Poor	2.00	34.00	2.00

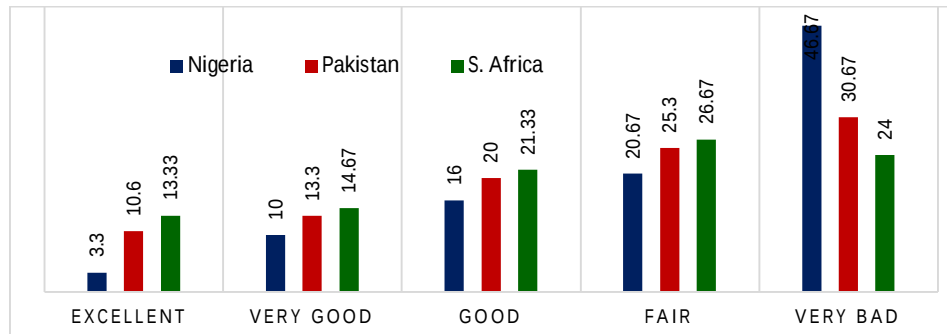


Figure 2: Responses to self-isolation policies by senior citizens across the countries

The results show that most of the respondents (Nigeria, 46.67%, Pakistan, 30.67% and South Africa, 24.9%) expressed their concerns that they were not satisfied with the self-isolation policy of COVID-19 in all three countries, where many of them thought very bad or fair (Figure 2). Given their strong family ties and dependence on social networks, respondents were deeply shocked by the isolating effect of SIP, especially when they contracted COVID-19. According to the WHO (2022a), 12.7 million people have died because of the COVID-19 pandemic, with 85% of those deaths occurring in low and middle-income countries. Most of these fatalities (83%) have involved elderly adults, some of whom, WHO claimed, were not counted. National Institute on Ageing (2019) opined that human beings are social creatures that depend on connections for thriving and survival; self-isolation defeats the ability to connect and deprives the elders of socialisation. Moreover, social isolation might result in cognitive decline, depression, and heart disease, which might necessitate considering the self-isolation policy as bad for the elderly. Holt-Lunstad *et al.* (2015) affirmed a high degree of association between loneliness and early mortality. They further added that stress levels and blood pressure were higher during loneliness, which may be considered as dangerous as obesity, blood pressure, and smoking.

Impact of self-isolation on the psychosocial states of the respondents

The data in Table 3 presents the perceptions and psychological impacts of the Self-Isolation Policy (SIP) among the elderly populations in Nigeria, Pakistan, and South Africa. The findings reveal variations in how the elderly across these countries experience and respond to SIP.

Firstly, the belief that “SIP is dangerous to one’s health” was relatively consistent across the three countries, with mean scores of 3.05 (Nigeria), 3.08 (Pakistan), and 3.10 (South Africa), indicating a generally moderate to high concern about the health risks associated with SIP. Pietrabissa and Simpson

(2020), Army (2019), and Rauschenberg *et al.* (2021) have shown that chronic social isolation increases the risk of mental health issues like depression, anxiety and substance abuse, as well as chronic conditions like high blood pressure, heart disease and diabetes. It also raises the risk of dementia in older adults (Valtorta & Hanratty, 2012; Nakou, *et al.*, 2025). The need for physical exercise among the elderly is always emphasized. Physical activity, according to the World Health Organization (2023), is a protective factor for noncommunicable diseases such as cardiovascular disease, stroke, diabetes, and some types of cancer. Schuch *et al.* (2016) and the WHO (2022a) associated physical exercise with improved mental health and a delay in the onset of dementia. and improved quality of life and well-being (Das and Horton, 2012; Wang *et al.*, 2021).

However, differences emerged in the statement “Self-isolation policy creates fear in me,” where Pakistan (Mean = 3.53) and South Africa (Mean = 3.44) reported higher levels of fear compared to Nigeria (Mean = 2.87). This suggests that the elderly in Pakistan and South Africa felt more psychologically threatened by SIP than their Nigerian counterparts.

Similarly, the perception that “Self-isolation hurts my mind, mood, and body” was slightly higher in South Africa (Mean = 3.16) than in Nigeria (Mean = 3.02) and Pakistan (Mean = 3.05). This indicates that South African elderly individuals experienced greater psychological and physical discomfort due to SIP. Most elders take pleasure in community meetings as they provide them the opportunity to bond with neighbours and friends. According to (RUSH, 2022), physical bond with loved ones enhances the release of oxytocin, which promotes happiness and calmness in individuals.

Interestingly, the statement “SIP does not affect me” had lower mean scores, particularly in South Africa (Mean = 2.48), suggesting that most elderly individuals did feel impacted by SIP. This trend was also observed in Nigeria (Mean = 2.85) and Pakistan

(Mean = 2.75), indicating a general consensus that SIP did affect their lives.

Feelings of loneliness due to SIP were notably higher in South Africa (Mean = 3.64) compared to Nigeria (Mean = 3.08) and Pakistan (Mean = 2.94). This suggests that the social isolation aspect of SIP was more strongly felt by the elderly in South Africa, possibly due to differences in family structures, community support, or social engagement patterns.

Regarding the positive impact of SIP, such as “SIP enables me to be full of energy,” mean scores were generally low across all three countries, with Nigeria at 2.71, Pakistan at 2.82, and South Africa at 2.56. This indicates that SIP was not perceived as an energising or beneficial experience by the elderly population.

Anxiety and sleep disorders were reported highest in South Africa (Mean = 3.64), followed by Nigeria

(Mean = 3.37) and Pakistan (Mean = 3.15), suggesting that SIP contributed to mental health challenges, particularly in South Africa.

Similarly, reduced physical activities and community participation were more pronounced in South Africa (Mean = 3.44) compared to Pakistan (Mean = 3.18) and Nigeria (Mean = 3.08). This reflects the restrictive impact of SIP on the elderly's mobility and social life.

Finally, the perception that “SIP can kill faster than COVID-19” was lowest in South Africa (Mean = 2.56), while Nigeria (Mean = 2.89) and Pakistan (Mean = 2.84) showed slightly higher agreement. This suggests that while the elderly feared SIP's psychological impacts, they still considered COVID-19 a more direct physical threat... As of 29 November 2022, the World Health Organization (2022a) reported a total of 638,175,811 confirmed cases of COVID-19 globally, including 6,612,970 associated deaths.

Table 3: Psychological impacts of self-isolation policy in the elderly population

	Nigeria		Pakistan		
	Total	Mean	Total	Mean	Mean
SIP is dangerous to one's health	458	3.05	462	3.08	3.1
Self-isolation policy creates fear in me	431	2.87	530	3.53	3.44
Self-isolation hurts my mind, mood and body	454	3.02	458	3.05	3.16
SIP does not affect me	428	2.85	413	2.75	2.48
I felt lonely with SIP	462	3.08	442	2.94	3.64
SIP enables me to be full of energy	401	2.71	423	2.82	2.56
Anxiety and sleep disorder	505	3.37	473	3.15	3.64
Reduced physical activities/ community participation	462	3.08	478	3.18	3.44
I think SIP can kill faster than COVID-19	434	2.89	426	2.84	2.56

Results of one-way analysis of variance

The results of the ANOVA analysis presented in Table 4 reveal significant differences in how respondents experienced the impacts of SIP across several psychological and physical factors. Specifically, there was a highly significant difference in fear levels between groups ($F = 15.350$, $p = .000$), indicating that SIP triggered varying levels of fear among different categories of respondents. Similarly, the impact of SIP on the mind, mood, and body was also significantly different across groups ($F = 14.421$, $p = .000$), suggesting that the psychological and emotional responses to SIP were not uniform.

Anxiety and sleep disorders showed a statistically significant difference between groups ($F = 6.265$, $p = 0.014$), although the effect size was smaller compared to other factors. This indicates that while SIP influenced anxiety and sleep patterns, the extent of this impact varied moderately among respondents. Additionally, reduced physical activities were found to

differ significantly between groups ($F = 12.602$, $p = 0.002$), pointing to diverse experiences in physical well-being and activity levels during the SIP period.

Lastly, respondents' overall response to SIP was significantly different across groups ($F = 10.337$, $p = 0.001$), implying that demographic or socio-economic factors might be responsible for these variations. These findings suggest that the effects of SIP are multifaceted, influencing individuals differently depending on their group characteristics, which may include factors such as age, gender, location, or socio-economic status.

The significant differences observed across all factors underscore the need for targeted interventions that consider these group-specific responses. Policymakers and mental health professionals should therefore design customized support mechanisms to address the varied psychological and physical challenges posed by SIP.

Table 4: ANOVA findings

Factors		Df	SS	MS	F	Sig.
Fear	Between Groups	1	1367.060	1373.070	15.350	.000**
	Within Groups	349	9082.91	90.754		
	Total	350	10 375.991			
SIP impacts the mind, mood and body	Between Groups	2	64.021	64.021	14.421	.000**
	Within Groups	348	475.006	4.430		
	Total	350	539.026			
Anxiety & sleep disorder	Between Groups	1	1.509	1.509	6.265	.014*
	Within Groups	344	25.411	.230		
	Total	345	27.910			
Reduced physical activities	Between Groups	1	3.536E-02	3.536E-02	12.602	.002**
	Within Groups	344	3.827	3.568E-02	19.607	.001**
	Total	345	3.853			
Response to SIP	Between Groups	1	249.009	249.009	10.337	.001**
	Within Groups	349	2415.982	21.963		
	Total	350	2664.991			

*Field survey, 2020. [Df = Degree of freedom; ** Significance at $P \leq 0.01$; * Significance at $P \leq 0.05$]*

CONCLUSION AND RECOMMENDATIONS

The study shows that senior citizens across Nigeria, Pakistan, and South Africa share similarities such as being largely literate, religious (mainly Christian or Muslim), and living in family-oriented households. However, differences emerged in gender composition, marital status, household size, and economic activity. Notably, more South African seniors remained economically active post-retirement, while larger household sizes and lower education levels were more common in Pakistan. These variations highlight the role of cultural and socioeconomic contexts in shaping the well-being of older adults during the pandemic.

The study revealed that elderly respondents in Nigeria and South Africa largely had small social networks, while those in Pakistan reported more diverse and larger networks, potentially offering better psychosocial support. Cultural caregiving norms differ, with African seniors relying on extended kin and community, while Pakistan shows a shift toward nuclear support systems. Perceptions of neighbourhood safety also varied, with South African seniors feeling the safest and Pakistani seniors reporting the most insecurity, factors that significantly affect social engagement and well-being.

A significant proportion of elderly respondents in Nigeria, Pakistan, and South Africa were dissatisfied with the COVID-19 self-isolation policy, primarily due to its disruption of vital social connections. The emotional toll of isolation was particularly severe in cultures with strong family and communal ties. Given

evidence linking social isolation to cognitive decline, depression, and increased mortality, self-isolation policies, while protective against infection, may have inadvertently harmed the psychosocial well-being of older adults.

The findings suggest a shared concern among elderly respondents in Nigeria, Pakistan, and South Africa about the negative health impacts of the Self-Isolation Policy (SIP). With moderate to high agreement that SIP is dangerous to health, the results align with existing evidence linking prolonged isolation to mental and physical health risks. The need for regular physical activity and social interaction remains critical for older adults' well-being, underscoring the importance of more inclusive public health strategies during pandemics.

The psychological impact of the Self-Isolation Policy (SIP) varied across the three countries, with elderly respondents in South Africa and Pakistan reporting greater fear, loneliness, and mental distress compared to those in Nigeria. SIP was generally perceived as harmful to mood, mind, and body, with little positive impact noted. Feelings of anxiety, reduced physical activity, and disrupted sleep were especially pronounced in South Africa. Despite recognizing the dangers of SIP, many still viewed COVID-19 as the greater threat, highlighting the complex balance between protecting physical health and preserving psychosocial well-being among older adults.

The ANOVA results reveal significant differences in how elderly respondents experienced the effects of the

Self-Isolation Policy (SIP), particularly in fear levels, psychological distress, physical activity, and sleep. These variations suggest that SIP's impact was not uniform, likely influenced by demographic or socio-economic factors.

The Self-Isolation Policy (SIP), while vital for curbing COVID-19 transmission, had profound negative impacts on the mental, emotional, and physical well-being of senior citizens—triggering fear, loneliness, anxiety, and reduced social and physical engagement across Nigeria, Pakistan, and South Africa.

The study recommends that the need to develop targeted mental health support and safe social engagement options to reduce loneliness among the elderly during isolation. Strengthen family and community care, especially in urban settings where traditional support is declining. Enhance culturally sensitive public health messaging to address fears and misconceptions. Promote inclusive policies that consider age, gender, and socio-economic factors for better elderly well-being.

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