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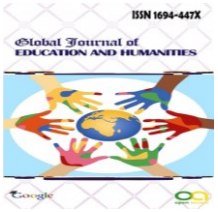

RESEARCH ARTICLE

Knowledge And Awareness of Old Age Related Health Problems among Residents of Edo State

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ABSTRACT

This study examines knowledge and awareness of old age related health problems among residents of Edo state. The population of the study consisted of persons who are 18 years and above that are residing in Edo state. The study adopted cross-sectional survey design. The sample consists of 559 respondents from Edo state was selected through multi-stage sampling technique. The major instrument for data collection was the questionnaire, though FGD guide was also used as complementary instrument. Nine research questions and four hypotheses were formulated for the study. The data collected from the respondents were analyzed using chi-square (χ2) statistics. The findings among others established that majority of the respondents have knowledge and were aware of old age related health problems. The study further established from the hypotheses there was a statistically significant relationship (P<.000) between educational level and knowledge of old age related health problems. The findings revealed that there was a statistically significant relationship (P<.000) between age and knowledge of old age related health problems. Therefore, based on the findings the study recommended that government should intensify its efforts to ensure that all categories of people are well educated as well as carrying out enlightenment campaign for all age groups.

Keywords: *Old Age Related Health Problems; Edo State; Civic Education*

Introduction

The number of persons that are 60 years and above has been on the increase all over the world. In the year 2000 older persons were 10% of the world population (UN Population Division, 2000). Projections are that the population of older adults will increase from 1.2 billion in 2025 to 2 billion in 2050 representing 21% of the total world population (UN Population 2008; UN Program on Ageing, 2009). Population of older persons is growing faster than rest of the population at the rate of 2% per year, but will jump to growth rate of 2.8% between 2025 and 2030 (Help Age International, 2010). According to UN Population Division (2011), the world population projection will increase 3.7 times from 1950 to 2050, but the number of those that are 60 years and above will increase by a factor of nearly 10%. UN Population Division (2011), went on to say that among older adults, the oldest old is projected to increase by a factor of 2.6. Also, projections are that by 2025, one out of every four persons, 25% in the developed countries will be 60 years or older (UN Population Division, 2009).

In Sub-Sahara Africa (SSA), it is expected that the number of older adults will increase from 42.6 million in 2010 to 160 million by 2050; making it the highest compared to any other region of the world (UN Population Division, 2008; Aboderin, 2010; UN Development Programme, 2010). It is estimated that by 2025, of Nigerians age 60 and above will constitute 6% of the population, and by 2050 it will the population constitute above 10% of the population (UN Population Division, 2008). The United Nations (2006) predicts that the percentage of the Nigerian population aged 60 years and above will increase by 26% by 2020 and 38% by 2050. This means that the number of older adults to be supported and cared for will grow significantly.

Everhuis, et al. (2000) and Hogan, Macknight and Bergman (2003) are of the view that ageing involves simultaneous process that take place at biological and physiological levels; for example, as the ability of cells to replicate themselves decrease with time ageing becomes obvious. These being the case, changes of different kinds are bound to occur especially in health. Also, Gureje, Kola and Afolabi (2007) believe that old age brings about health problems and functional incapacity which may affect the sense of wellbeing of an individual. Scholars like Abdulraheem and Abdulrahman (2008) and Nicholas, Nicri and Brain (2006) reported that there are many chronic health problems confronting older adults which prevent them from functioning at the same level they used to when they were younger. Some of such health problems include alzheirmers, arthritis, hypertension, stroke, cancer, osteoporosis, eye problems, incontinence etc. Azodo (2010) also support the above view by saying that older adults exhibit limited regenerative abilities and are more prone to diseases, syndromes and sickness.

The amount of knowledge possessed by relatives of older adults and other people concerning old age-related health problems influence the care giving, quality of life (QoL), perception and management of the health challenges (Azodo, 2010; Gureje, et al., 2007; Institute of Medicine (IOM), 2004; Bass, 2005). This is consistent with US Department of Health and Human Services (2004) position that adequate knowledge of chronic non-communicable diseases of the older adults is essential to their care givers in order to improve the quality of life of the older adults. Most of the old age-related diseases are asymptomatic before the old age years (Atulomah, Olarenwaju, Amosu & Adedeji, 2010). Therefore, if relatives are knowledgeable enough to handle old age related health issues at the asymptomatic stage, it will go a long way to improve the health of the older adults.

In order to better handle age related health problems or chronic non-communicable diseases of the older adults, there is need for accurate understanding, knowledge and awareness of the health problems of this age group. According to Aboderin (2010) and Hassali, Shafie, Kalid and Hali (2009) quality of life of the older adults depend on the amount of knowledge of old age related health problems that people around them possess. This is because knowledge of old age related health problems have been found to be associated primarily with health and functional status of the older adults. According to Greene and Kamimura (2003) attitudinal dispositions, cognitive complexity, education, age, place of residence, household income, marital status among others are factors that influence awareness and knowledge. This is consistent with Denton, Prus and Walters (2004), Bzostek, Goldman and Pebley (2007), positions that socioeconomic status (SES) as well as demographic characteristics significantly predict the knowledge level and rate of change in the number of physical limitations, chronic diseases and depressive symptoms among adults especially those that are 60 years and above.

Social work draws from models of health promotion and disease prevention to meet the needs of contemporary health-related social issues throughout the life-span of individuals. According to Cooper (2003) and Fulmer (2005) in the field of gerontology, health promotion is applied to chronic illness, including, but not limited to, cancer, alzheimer's disease, arthritis, hypertension, stroke and osteoporosis. Social workers strive to implement a broad

range of health awareness programmes in response to increasing aging of the population and the inevitable increase in the health care needs of this population.

This being the case, social work profession is fundamentally committed to individuals, family development, community organization and advocacy. Its interventions incorporate the skills and values necessary to implement effective health awareness practice at multiple systemic levels. For example, using public education, counseling, networking, conferences and seminars among others can properly address prevalent diseases and health issues of older adults (Rizzo & Seidman, 2010).

Many studies have been carried out on health issues of older adults by scholars like Abdulraheem and Abdulraman (2008), Aboderin (2008), Atuloma, et al. (2010), however, none of these studies looked at the knowledge of old age related health problems among the older adults. For instance, whereas Atulomah, Olanrewaju, Amosu and Adedeji (2010) looked at the issue of level of awareness, perception and screening behaviour regarding prostate cancer among men in a rural community of Ikenne local government area of Ogun state, Nigeria, Abdulraheem and Abdulrahman (2008) studied morbidity pattern among the older adult population in a Nigerian tertiary health care institution. Thus, this study tends to look at the knowledge and awareness of old age related health problems among residents of Edo state through the following questions

1. Does level of education people residing in Edo state affect knowledge of old age related health problems?
2. Does age of people residing in Edo state affect knowledge of old age related health problems?

Literature Review

Knowledge and awareness of some old age health issues

More people are getting old all over the world as a result of improved medical procedures and improved standard of living (WHO Population Division, 2008). Older adults are susceptible to chronic non communicable disease as a result of reduced efficiency of cardiovascular and reduced ability of their cells to replicate (Abdulraheem & Abdulraman, 2008; Badoe, Archampong & Rocha, 2000). Scholars like Aboderin and Ferreira (2009), Daar, Singer, Persad, Pramming, Matthews and Beaglehole (2009), have argued that the general age spectrum lack adequate knowledge, information and awareness of most CNCDs. They believe that most of the age related disease can be avoided or reduced at the asymptomatic stage before old age with adequate knowledge, information and awareness. This position is consistent with Africa Union/HAI (2003). WHO (2010) argued that older persons population in Sub-Sahara Africa (SSA) of which Nigeria is not an exception, seemed to be at particularly high risk of ill health and disability from age related chronic non-communicable diseases due to a life time of exposure to conditions of deprivation and a growing prevalence of modifiable CNCDs risk factors. Also, older adults are believed to lack access to even basic health care and crucially to have access to information cum services than do younger age groups, hence suggesting an element of age related exclusion. This being the case, it therefore calls for the ascertainment of the level of information, knowledge and awareness of old age related Chronic Non-Communicable Diseases.

Older adult and health issues

Population is ageing and there is a rising exposure to modifiable risk factors such as tobacco use, unhealthy diet, inadequate knowledge/awareness of health issues and a lack of physical activity, and the likes are fostering a growing burden of age related CNCDs in Sub-Saharan Africa (WHO, 2005; Aboderin, 2010). Most prominent among the disease are prostate cancer, breast cancer, hypertension, diabetes, stroke, arthritis and visual impairment (WHO, 2006). At individual level, evidence shows that older persons suffer additionally from other CNCDs like muscular-skeletal condition, mental disorders such as dementia, depression and azheimer's disease (Gureje, Kola &Afolabi, 2007; Gureje, Ogunniyi & Kola, 2006). Yet very limited health policy and understanding exist despite the magnitude, patterns, dynamics, social determinants and individual cum social impact of ill-health in older adult population across societies (Aboderin, 2010). Despite the fact that a first review and appraisal of Madrid International Plan of Action (MIPAA) implementation in Africa was conducted in 2007 there is lack of insight on what specific strategies have been formulated, approved or executed across SSA countries (Aboderin & Guchuhi, 2007; Aboderin, 2008; Aboderin, 2010). Indications are that (with a few notable exceptions) very little effective policy action has been ensured. Nigeria health system remain largely inaccessible and unresponsive to older adults and age related CNCDs (Aboderin& Ferreira, 2008; Aboderin & Guchuhi, 2007). Aboderin (2010) however, maintained that the dearth of systematic information in Nigeria's health sector regarding the nature and specific short coming

of CNCDs of the older adults and health service provision are the key impediments to effective policy action. This is because the older adults are excluded from the programme of National Health Insurance Scheme (NHIS), hence the emphasis is on the working class and those that can afford or contribute to the scheme. However, some of the older adults put the financial strength into consideration, making it clear that they cannot participate in the scheme.

Theoretical Framework

This study will adopt attribution theory as its theoretical framework. Attribution theory is a motivational/social psychology theory developed by Fritz Heider in 1958. The theory looks at how the average person constructs the meaning of an event based on his/her motive to find a cause and based on his/her knowledge of the environment. In other words, the theory is concerned with the ways in which people explain (or attribute) the behavior of others or themselves with something else. It explores how individuals 'attribute' causes to event and how this cognitive perception affects their usefulness in the society. Heider believes that people are naïve psychologists trying to make sense of the social world. Also that people tend to see cause and effect in relationships, even when there is none. The major criticism of this theory is that it fails to address the social, cultural and historical factors that shape attributions to cause.

This theory is considered as the framework of this study because of it contributions to the understanding of individuals' behaviour. It will guide in advancing the understanding of how people are predisposed to knowledge on social issues as it relate to health behaviours. Attribution theory deals with how the individual uses information to arrive at causal explanation for events. It examines what information is gathered and how it is combined to form a causal judgment (Fiska & Taylor, 1991).

The way an individual attributes causality to health problem of older adults can affect the way the individual seeks knowledge or become aware of the illness. For example, if an individual attributes external causes such as money, negligence of relations, tradition, norms and culture to be responsible for certain health problems, the knowledge and awareness of such illness may be affected if those situations are not prevented. This means that the individual will not know much about a particular health problem or make any effort to know about any illness because he/she do not consider him/herself to be in the situation that can bring about such illness. However, if an individual attributes causality to disposition, there may be the tendency for the individual to seek knowledge and awareness of the health problem in order to mitigate the consequence of the illness or prevent it.

This being the case, when illnesses are attributed to old age, it is likely to be followed by bias and stereotypes like: 'older adults are old school', they complain too much, they are always sick, it is natural for them (older adults) to be sick. As a result of the above, the relations may not listen or do anything to help the older adults.

Therefore, knowledge and awareness of old age related health problems among residents of Edo state is most likely predicated on the kind of attribution the individual attach to the concept 'old age related health problems. If the attribution people have for the older adults is based on stereotype or bias, it can negatively affect their level of knowledge/awareness of old age related health problems and the level of care. On the other hand, if rational and objective attribution is maintained concerning the older adults it can increase knowledge and awareness of old age related health problems. In other words, attribution is most likely a result of individual knowledge base.

Methods

The study adopted the cross-sectional survey. According to Babbie (2007) and Obikeze (1990) the cross-sectional design is suitable for collecting information from a cross-section of a study population at a particular point in time. The design is preferred because of economic reasons and time frame demanded for this study. Edo state is located at an elevation of 87.88 meters above sea level. Its coordinates are $6^{o}20'$ 6" N and 5^{o} 36'13" E. Its Universal Transverse Mercator (UTM) Zone is 31N (Izoya, 2014). Edo state also known as the 'Heart Beat of the Nation' is an inland state in the south-south part of Nigeria. Its capital is Benin City. This study focuses on persons who are 18 years and above that are residing in Edo state. According to National Population Commission (NPC) (2006) the population of Edo state is estimated to be 3,233,366 (male:1,633,946; female: 1,599,420). Edo state is made up of 3 senatorial zones and they are: Edo South Senatorial Zone, Edo Central Senatorial Zone, and Edo North Senatorial Zone. To obtain the sample size required for this study, Cochran (1963) statistical formula below was adopted to arrive at 566. The multi-stage cluster sampling technique will be adopted. The researcher employed both qualitative and quantitative procedure. The questionnaire and Focus Group Discussion (FGD) guide was used as the main instruments for data collection. To achieve holistic analyses, this study will employ both quantitative

and qualitative methods of data analysis. In doing this, the quantitative data from the questionnaires will be coded; computer processed and analyzed using the Statistical Package for Social Sciences (SPSS) version 21 The FGD was manually analyzed. Phrases from relevant sections of the transcript was identified and they served as illustrative quotes to complement the quantitative data.

Findings

Table 1: Distribution of respondents by age

Age Interval	Frequency	Percentage (%)
18-29	206	36.9
30-39	243	43.5
40-49	74	13.2
50-59	31	5.5
69 and above	5	.9
Total	559	100.0
Level of education	Frequency	Percentage (%)
No formal education	90	16.1
FSLC	70	12.5
"O" level certificate	175	31.3
NCE/OND /GCE "A" Level	110	19.7
HND/First Degree	73	13.1
Higher Degree	41	7.3
Total	559	100.0

Source: Field Survey, 2021

The data in Table 1 shows the distribution of respondents according to their age range. The result from the table indicates that ages of respondents are spread across each of the categories such that 36.9% are in the age category of 18-29 years, 43.5% in the age category of 30-39 years, 13.2% in the age category of 40-49 years, 5.5% in the age category of 50-59 years and 0.9% are in the age category of 69 years and above. A closer look at the table also shows that respondent within the younger age category (18-39years) are more in number while the number continue to drop as the age category progressed. It can also be observed that majority of the respondents (43.5%) were within 30-39 years. This may be as a result of unemployment as many of them are youth who were not engaged as such was available during the period of the field survey.

The data in Table 1 above show the distribution of respondents by level of education. Result indicates that 16.1% of the respondents have no formal education. Also, 12.5% have First School Leaving Certificate (FSLC), 31.3% have "O" level certificate, 19.7% have NCE/OND /GCE "A" Level, 13.1% have HND/First Degree and 7.3% have Higher Degree. This result suggests that on a general note, majority of the respondents (31.3%) have "O" level certificate

Table 2: Distribution of Respondents on knowledge of old age related health problems

Knowledge	Frequency	Percentage (%)
Yes	521	93.2
No	38	6.8
Total	559	100.0
Awareness	**Frequency**	**Percentage (%)**
Yes	506	90.5
No	53	9.5
Total	559	100.0

Source: Field Survey, 2021

As shown in Table 15 above, almost all of the respondents (93.2%) have knowledge of old age related health problems. On the contrary, only 6.8% were not aware of old age related health problems. This result is suggestive of the fact that on a general note, majority of the respondent was aware of old age related health problems.

In a similar manner, qualitative data were obtained from the FGD respondents regarding their view on the four major health problems, one of the group participants a younger respondent said,

> "in fact the most worrisome of all the sickness disturbing elderly people that i know is arthritis. My brother this sickness is too much. It can disfigure old people's legs and make them cripple. To be truthful, i cried when i met women and couldn't stand up to walk except with the support of a walking stick. This sickness is very bad"

Another respondent, an older respondent said this:

> "You see, it is not only arthritis that is the problem, do you know stroke is also a disturbing health problem among the aged. Some of them cannot do anything because either their hands or legs cannot adequately function. In short, some cannot stand to go to the toilet to ease them. So require somebody to assist them in bringing bucket to defecate. I had such experience. It is really an ugly experience to have"

As shown in table 2 above, almost all of the respondents (90.5%) were aware of old age related health problems, only 9.5% were not aware of old age related health problems. This implies that majority of the respondents are aware of old age related health problems.

Data from FGD revealed that all the group participants are aware of old age related health problems. For example, a younger group participant affirmed thus:

> "it is not a secret about diseases that disturb old people. Even if you don't have or living with an old person, you must have seen an old person in your neighbourhood and so we are aware of old people and diseases that disturb them. But you see, some of these diseases that old people suffer are not ordinary. Some of them are caused by witches and evil people. Secondly, some bad life style one lived turned around hunting him/her in her old age. You see some of the disease that disturbs old people is not same with that of younger people. Old people suffer from stroke, coughing, arthritis and others but young people suffer a lot from malaria, pneumonia, fever among others. That does not mean that old people do not suffer from the same illness. We are aware of diseases that buffet old people"

Test of Hypotheses

Table 3: Cross tabulation of educational level and knowledge of old age related health problems

Educational level	Knowledge of old age related health problems		Total
	Yes	No	
Low level education	332(96.1%)	13(3.9%)	335(100.0%)
High level education	199(88.8%)	25(11.2%)	224(100.0%)
Total	**521(93.2%)**	**38(6.8%)**	**559(100.0%)**

$\chi 2$ = (N=559), 11.229; df=1, p<.001, critical value=3.841
Source: Field Survey 2018

Table 3 above presents data on which hypothesis one is tested. To test the hypothesis, educational level (Table 3) was cross tabulated with knowledge of old age related health problems as presented in Table 15. Educational qualification as presented in section Table 3 was re-coded as follows; all those that have no formal education, FLSC, "O" level certificate and SSCE were re-coded as "low level education" while all those that have NCE/OND /GCE "A" Level, HND/First Degree and Higher Degree were re-coded as "high level education". Respondents were grouped into two, those who have low level education and those who have high level education. Also, knowledge of old age-related health problems was recoded as follows: all those who can name some of the older adults' diseases were re-coded as "yes" while all those who cannot name some of the older adults' diseases were re-coded as "no". The respondents were therefore grouped into two categories; those indicated yes to knowledge of old age related health problems and those who indicated no to knowledge of old age related health problems.

The result shows that almost all the respondents who have low level education 96.1% agreed that they have knowledge of old age related health problems, only 3.9% did not agree that they have knowledge of old age related health problems. On the other hand, of all those who have high level of educational 88.8% affirmed that they have knowledge of old age related health problems and 11.2% did not agree that they have knowledge of old age related health problems.

Rejection region: If $p \leq .05$ reject the null hypothesis (H_o), but if $p > .05$, we accept the null hypothesis. The test is a one-tailed test.

Decision

With the computed $\chi 2 = 11.229$; df=1, critical value =3.841 the test shows that there was a statistically significant relationship (P<.001) between educational level and knowledge of old age related health problems. Therefore, the substantive hypothesis which states that respondents with higher level of education are more likely to have more knowledge of old age related health problems than those with lower level of education is hereby upheld. As a result, the null hypothesis which states that there is no statistically significant relationship between level of education and knowledge of old age related health problems is hereby rejected.

Hypothesis Two

H_1: Older respondents are more likely to have more knowledge of old age related health problems than younger respondents.
H_o: There is no statistically significant relationship between age of respondents and knowledge of old age related health problems

Test Statistic: The Chi square ($\chi 2$) statistic is employed in testing this hypothesis.

Significance Level: A significance level (α) of 0.05 was used in testing this hypothesis.
Statistical computation
Table 4: Cross tabulation of age of respondents and knowledge of old age related health problems

Age	Knowledge of old age related health problems		Total
	Yes	No	
Younger respondents	429(95.5%)	20(4.5%)	449(100.0%)
Older respondents	92(83.6%)	18(16.4%)	110(100.0%)
Total	**521(93.2%)**	**38(6.8%)**	**559(100.0%)**

$\chi 2$ = (N=559), 19.779; df=1, p<.000, critical value=3.841
Source: Field survey 2018

Table 4 above presents data on which hypothesis two is tested. To test the hypothesis, age of respondents (Table 2) was cross tabulated with knowledge of old age related health problems (Table 15). Age of respondents as presented in section A of the questionnaire was re-coded as follows; all those between the ages of 18 to 39 years were re-coded as "younger respondents" while all those between the age of 40 years and above were re-coded as "older respondents". Respondents' were grouped into two, younger respondents and older respondents. The result shows that almost all the younger respondents (95.5%) agreed that they are know of old age related health problems, only 4.5% did not agree that they are know of old age related health problems. On the other hand, of all those who are older respondents 83.6% affirmed that they know of old age related health problems and 16.4% did not agree that they are know of old age related health problems.

Rejection Region: If $p \leq .05$ reject the null hypothesis (H_o), but if $p > .05$, we accept the null hypothesis. The test is a one-tailed test.

Decision

With the computed $\chi 2 = 19.779$; df=1, critical value =3.841 the test shows that there was a statistically significant relationship (P<.000) between age and knowledge of old age related health problems. Therefore, the substantive

hypothesis which states that older respondents are more likely to have more knowledge of old age related health problems than younger respondents is hereby upheld. As a result, the null hypothesis which states that there is no statistically significant relationship between age and knowledge of old age related health problems is hereby rejected.

Hypothesis Three

H_1: Female respondents are likely to be more aware of old age related health problems than male respondents.
H_0: There is no statistically significant relationship between sex of respondents and awareness of old age related health problems

Discussion

First, the study sought to ascertain the level of knowledge of old age related health problems among residents of Edo state. According to the findings of this study almost all the respondents whose annual income is low 94.8% agreed that they have knowledge of old age related health problems while 100.0% of all those whose annual income is high affirmed that they have knowledge of old age related health problems. Overall, this result reveals that majority of the respondents whose annual income is low agreed that they have knowledge of old age related health problems while all those respondents whose annual income is high also agreed that they have knowledge of old age related health problems. This shows that knowledge of old age related health problems does not depend on income level. This result contrasts with the findings of Soonrim, Heejung, Choonji, and Miyoun (2012), who found that monthly income of 300,000 Korea Republic Won or more and better knowledge and attitude about aging were associated with enhanced life satisfaction.

On the level of awareness of old age related health problems by residents in Edo state. The result in table 35 reveals that all those (100.0%) who reside in urban areas are awareness of old age related health problems. Meanwhile, more than half (80.5%) of those who reside in rural areas affirmed that they are awareness of old age related health problems and 19.5% of the respondents indicated that they are not awareness of old age related health problems. Overall, this result reveals that all the respondents (100.0%) in the urban area are aware of old age related health problems while majority (80.5%) of the respondents in the rural area are also awareness of old age related health problems. This shows that there is general awareness of old age related health problems. This finding contradicts the findings of Gemalmaz and Oge (2007) who found that among the women, 60.8% had heard of osteoporosis and 44.9% had the correct definition of osteoporosis. Awareness and accurate definition of osteoporosis was high in younger and high educated women (p<0.001). They concluded that there was a general unawareness of osteoporosis among the women.

The findings further revealed that there was a statistically significant relationship (P<.001) between educational level and knowledge of old age related health problems. This finding is in line with Gemalmaz and Oge (2007) who studied knowledge and awareness about Osteoporosis and its related factors among rural Turkish women. The study revealed that among the women, 60.8% had heard of osteoporosis and 44.9% had the correct definition of osteoporosis. Awareness and accurate definition of osteoporosis was high in younger and high educated women (p<0.001).

Conclusion and Recommendation

The present study has made a number of findings, which are conclusively presented as follows: majority of the respondents know and are aware of old age related health problems. The study found that there was a statistically significant relationship (P<.000) between educational level and knowledge of old age related health problems. The findings revealed that there was a statistically significant relationship (P<.000) between age and knowledge of old age related health problems. These findings brings to the fore, the importance of these factors in designing any form of intervention programmes (within the study area and areas with similar socio-cultural environment) which will focus on old age related health problems. These findings can help in knowing where to focus and how to adopt strategies that can produce the desired effects. Based on the information elicited from this study, the research therefore would like to make the following recommendations.

1. In view of the opinion of the respondents, government should intensify its efforts to ensure that all categories of people are well educated. This will reduce disparity in knowledge and awareness of old age related problems
2. Enlightenment campaign should be carried out for all age groups. This is in view of the fact that some of the older respondents as well as younger respondents are yet to know or be aware of old age related health problems
3. Lastly, it is the recommendation of the researcher that government should not relent in its efforts to sensitize or educate people residing in urban and rural areas. This will also help to allow some residents who are yet to know and be aware of old age related problems to know and be aware of old age related problems

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