HEALTH CARE SEEKING BEHAVIOUR AMONG THE AGED IN NIGER STATE, NIGERIA

BY

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A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA, INPARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS DEGREE IN EDUCATION

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION
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DECLARATION

I hereby declare that this thesis has been written by me and that is a record of my own research work, this research work was supervised by Prof. (Mrs.) M. A. Suleiman and Dr. Umaru Musa. It has not been presented in any previous application for higher degree, all quotations are indicated and the sources of the information are acknowledge through references

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Saba Mohammed

CERTIFICATION

The thesis entitled "HEALTH CARE SEEKING BEHAVIOUR AMONG THE AGED IN NIGER STATE" by **Mohammed Saba** meet the regulations governing the award of degree of Masters of Education (M.ed) in Health Education of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This project work is dedicated to Almighty Allah (SWT) for granting me the knowledge, health and guidance throughout the entire work, praises be to him.

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OPERATIONAL DEFINITION OF TERMS

Health care	Refers to services provided to individuals by medical professionals to prevent, manage and treat illness.
Seeking Behaviour	Refers to a ‘sequence of remedial actions’ taken to rectify ‘perceived ill-health.
Aged person	Refers to someone who is 60 years old and above

.

ABBREVIATION

UNDE	United Nation Department of Economic
NYSAPD	New York Special Affair Population Division
UN	United Nation
CTA	Centre for Technology Aging
NNHC	Nigerian National Health Conference
WHO	World Health Organization
AC	Action Congress
PDP	People Democratic Party
COPD	Chronic Obstruction Pulmonary Disease
RPM	Remote Patient Monitoring
RTS	Remote Training and Supervision
CDC	Centre for Disease Control
CPS	Community Preventive Services
AHRQ	Agencies for Health Care Research and Quality
HACC	Home and Community Care
NARI	National Ageing Research Institution
COTA	Council on the Ageing
CDSM	Chronic Disease Self-Management

ABSTRACT

The purpose of this study was to find out the health care seeking behaviour among the aged in Niger State. To achieve this purpose the ex- post facto research design was used to assess 399 respondents drawn from three senatorial zone of Niger State through stratified sampling technique. A closed ended questionnaire was used to obtain responses from the respondents, 400 copies of questionnaire were distributed to the respondents while 399 copies were received. Data collected for this study were analyzed using descriptive statistics of frequency counts, percentage mean and standard deviations and inferential statistics of ANOVA, scheffe post hoc test and independent t- test. 0.05 level of significance was used for all test of significance. The findings show that age has significant effect in health care seeking behaviour among the aged group in Niger State and poor health care seeking behaviour is present among age 80 years and above compared to 60 – 64 and 70 – 74 years respectively. It was concluded that age is a significant factor in decreasing healthcare seeking behaviour among the aged in Niger State. It was recommended that the government should embark on massive enlightment programes for the aged in other to educate them and encourage them on health services available to them and also seek them when needed. Cost reduction and disease management should also be considered.

CHAPTER ONE

INTRODUCTION

1.1. Background to the Study

Aging refers to a lifelong process and varies in its effect on individuals, and as commonly defined as beginning at the age of 65. (Hess, 2008). Aging is a process of becoming older, it represent the accumulation of changes in a person overtime (Bowen, Richard, Atwood, & Craig 2004). Aging is the gradual change in the structure of any organism that occur in the passage of time, that does not result from disease or other gross accidents and that eventually lead to the increased probability of death as the individual grows older (Miller 2003).

However, Ageing has become a global phenomenon and indeed a critical policy issue receiving some recognition by governments of developed countries where it is reflected in the government's vital document of economic and social development strategy (Okoye 2013). Furthermore, globally, the greatest increase in the number of older people is occurring in the developing and middle income countries. Nigeria is not an exception. Nigeria still has a relatively "young" population when compared to most European countries and other countries where life expectancy is high. However, as medical advances allow people to live longer, the proportion of the elderly will increase in Nigeria. (Okoye, 2013).

United Nations Department of Economics and New York Special Affairs Populations Division (2005) observes that the population of Nigerians aged 60 years and above is already increasing. United Nation's population profile (2005), shows that there were 5 million Nigerians aged 60 years and above in 2005 and the number will continue to increase by year 2025, it is estimated that 6% of the population will be 60years and

above. Abdulraheem (2007) states that it may be necessary for policy makers to consider establishing neighborhood adult day care centres where elderly persons can meet each other during the day. Other services like medical, nutritional, recreational and educational services can also be incorporated into the neighborhood day care centres. Okoye (2013), The use of adult day care centers has been reported by many scholars to be very advantageous to elderly persons and their families.

According to Mion (2003), the delivery of health care to the older adults has been recognized to be more complex than that of younger adults because, the elderly persons utilize the majority of health care service while the complex needs have implication for future health care delivery to the geriatric population, Specifically in Nigeria, where the number of elderly citizens has been on the increase and their health needs receiving popular recognition. Findings on elderly health issues can be used to guide the formulation of comprehensive health services and health education policies and intervention programs for elderly men and women in Nigeria, (World Health Organization (2006). Moe, (2012), highlighs that aging process and problems related to elderly should be better understood so that effective elderly health prevention can be planned and implemented. The need to improve the delivery of care for older adults in home and community settings will be unavoidable although the broad diffusion of transformative technologies offers a significant means to advance the effort of improving quality and reducing cost of care, (Centre for Technology and Aging, 2009).

1.2. Statement of the Problem

Health care services are a major component towards providing quality living, it is a common problem that such services has poise a greater challenges on the health seeking behaviour of the aged individual in Niger State. Health Care is a top social problem facing the aged today the lack of awareness of health care services has poised a

treat on the health of the aged, inadequate and poor health care facility management are some of the factors affecting the seeking behaviour of the aged towards practice and utilization particularly those residing in rural areas and poor implementation of National Health Policy. Majority of the aged persons had age associated illnesses such as blood pressure, cardiac problems, diabetes, joint pains, kidney infections, cancer and tuberculosis that take a long time to treat which particularly affect their health seeking behaviour. Aged individuals are found to have patronized traditional healers, resorted to self medication using local herbs or visit chemists' shops whenever they are sick. This research therefore seek to assess health care seeking behaviour among the aged in Niger State, Nigeria.

1.3 Purpose of the Study

The purpose of the study was :

i. to find out the effect of aging on health care seeking behaviour among the aged in Niger State;

iii. to find out the practice of the aged person on health care seeking behaviour in Niger State;

iv. to find out whether gender has any differences on health seeking behaviour among the aged in Niger State;

v. to find out whether the aged persons are aware of the health problems affecting them in Niger State; and

Vi. to find out whether educational level has influence on health seeking behaviour among the aged in Niger State.

1.4 Research Questions

In other to address the problem of this research, the following research questions were raised;

i What is the effect of aging on health care seeking behaviour among the aged in Niger State?

ii. What is the practice of the aged person on health care seeking behaviour in Niger State?

iii. Does gender has any differences on health seeking behaviour among the aged in Niger State?

vi. Are the aged persons aware of the health problems affecting them in Niger State?

v. Does educational level have any influence on health seeking behaviour among the aged in Niger State?

1.5 Significance of the Study

The outcome of this study will be significant in the following ways;

1. Motivate law makers to formulate policies regarding health of the aged persons by making sure that appropriate provision of health facility are made available for aged persons to access easily when needed in Niger State.

2. Reveal to individual and society including health centre that the aged persons in Niger State require constant support and care.

3. Non -governmental organization would also find this study useful in designing health education campaign for the aged persons in Niger State,

4. The findings or outcome of this study will be of greater benefits to future researchers while researching into similar studies.

5. Motivate the health educators to create awareness that exercise, proper diet and health information can promote heath while been aged in Niger State.

6. Enable the community based health workers organize health program for the aged in Niger State.

1.6 Major Hypothesis

There is no significant difference among the aged persons in health care seeking behaviour in Niger State.

Sub- Hypothesis

The following sub- hypothesis were formulated;

i. There is no significant effect of aging on health care seeking behaviour among the aged in Niger State.

ii. There are no significant differences on practice of the aged person on health care seeking behaviour in Niger State.

iii. There are no significant differences among gender on health seeking behaviour among the aged in Niger State.

vi. There are no significant difference in the awareness of the aged on health problems affecting them in Niger State.

v. There are no significant differences among aged of different educational qualification on health seeking behaviour among the aged in Niger State.

1.7 Basic Assumption

Based on this study, the following basic assumptions were formulated.

i. Effects of aging may be detrimental to health care seeking behaviour among the aged groups in Niger State.

ii. Practice may determine health care seeking behaviour among the aged groups in Niger State.

iii. Gender status may determine health care seeking behaviour among the aged groups in Niger State.

iv. Awareness may determine preventive health care seeking behaviour among aged groups in Niger State.

v. The aged level of education may determine their health care seeking behaviour among aged groups in Niger State.

1.7 Delimitation of the Study

The research was delimited to the study of health care seeking behaviour among the aged in Niger State, Nigeria. The respondents for the study comprise of all the male and female aged within the state.

1.8 Limitation of the Study

The study has the following limitation;

The study used questionnaire as its main instrument. Explanation was made on any statement that was not clear to the respondent.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

Health promotion programmes worldwide have long been premised on the idea that providing knowledge about causes of ill health and choices available will go a long way towards promoting a change in individual behaviour, towards more beneficial health seeking behaviour, (Mackian 2003). Furthermore, the growing recognition in both developed and developing countries that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behaviour , (Mackian 2003). An attempt is made in this chapter to review literature related to this investigation. The review is under the following sub- headings;

2.1. Concept of Aging

2.2. Concept of Health Care

2.3. Theoretical Framework on Health Care Seeking Behaviour among the Aged

2.4. Health Care Seeking Behaviour among the Aged Persons

2.5. Awareness of Health Care Service among the Aged Persons

2.6. Practice of the Aged towards Health Care Service

2.7. Health Problems Associated with Ageing

2.8. Utilization of Health Care Services and Support for the Aged Persons

2.9. Strategies For Promoting Healthy Ageing

2.10. Empirical Studies on Health Care Seeking Behaviour among the Aged

2.11. Summary.

2.1. Concept of Aging

Lopez- otin et al (2013) defines aging as a progressive functional decline or a gradual deterioration of physiological function with age including a decrease in reproductive abilities and increase in vulnerability. Aging is an increase in inflammation levels, that may contribute to several age- related disorders such as alzheimer's disease, atherosclerosis and arthritis (Franceschi et al 2000, Bruunsgaard et al 2001). According to gerontologist, Pedro (2013), aging as a complex process composed of several features, an exponential increase in mortality with age, physiological changes that typically lead to a functional decline with age, increased susceptibility to certain disease with age, aging is a progressive deterioration of physiological function, an intrinsic age- related process of loss of viability and increase in vulnerability. Aging is the process that converts fit people into fragile and frailer people with increased risk of illness, injury, death, and aging process is classified into six (6) stages, the period from 20 to 35 years of age resolves adulthood during which biological function and physical performance reach peak, the period from 35 to 45 years covers young middle age during which physical activity usually decline with 5 – 10 kg accumulation of fat, the period from 45 to 65 years covers later middle age during which women reach menopause and men also significantly reduce their output of sex hormones, the decrease in physical performance continues and may even accelerate, the period from 65 to 75 years covers the early old age, during which there may be a slight increase of physical activity to make use of during free time rebutting from retirement, the period 75 to 85 years is a middle old age during which many people have developed physical disabilities, the final stage is very old that covers period over 80 years during which people become totally dependent, usually, it is expected that people of that age will have 8 to 10 years of partial disability and a year of total dependence (Vankateswarlu 2011).

2.2 Concept of Health Care

The term health care is the prevention, treatment, and management of illness and the prevention of mental and physical wellbeing through the service offered by the medical and allied health profession. (Heritage, 2007). Farlex (2012) defines health care as the services provided to people or communities by agents of the health services or profession for the purpose of promoting, maintaining, monitoring or restoring health. WHO (2013), define health care as the diagnosis, treatment, and prevention of disease , illness, injury and other physical and mental impairment in human being. World Health Organisation further observes that health care embraces all the goods and services designed to promote health, including "preventive, curative and palliative interventions, whether directed to individuals or to populations. According to Wikipedia (2009) the organized provision of such services may constitute a health care system, Since health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases and the frontiers of health extend beyond the narrow limits of medical care, It is thus clear that "health care" implies more than "medical care."

It embraces a multitude of "services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring, or restoring health. It is important to note that health care consist of three (3) tiers namely the primary, secondary and tertiary health care level in Nigeria, the primary health care level is the medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system. This is often abbreviated as PHC (Primary Health Care) and it is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation

and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self- determination" (Alma Ata international conference 2005). Primary care, as the provision of essential health care, is the basis of a health care system. It provides both the initial and the majority of health care services of a person or population, This is in contrast to secondary health care, which is consultative, short term, and disease-oriented for the purpose of assisting the primary care practitioner. Tertiary care is for patients with unusual illness requiring highly specialized services. Primary health care clinicians may be physicians, nurses, or various other health workers trained for the purpose.

The term secondary health care is a service provided by medical specialists who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists. A physician might voluntarily limit his or her practice to secondary care by refusing patients who have not seen a primary care provider first, or a physician may be required, usually by various payment agreements, to limit the practice this way (Alma Ata international conference 2005). Furthermore, some areas of secondary care are also managed by allied health professions who work to co-manage that aspect of health care with physicians, such as occupational therapists and orthoptists. Secondary health care is also the intermediate level of health care, which is the responsibility of the state government. It provides mutually supportive referral sub-system to the primary health care. It is involved in curative as well as promotive services. Health institutions under the secondary level include: general hospitals, cottage hospitals and comprehensive health centres. Providers of services here are doctors, nurses, midwives, pharmacists, laboratory staff, x-ray technologists/technicians (Encyclopedia of Public Health 2009).

Tertiary health care is specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has personnel and facilities for special investigation and treatment. Specialist cancer care, neurosurgery (brain surgery), burns care and plastic surgery are examples of tertiary care services. In comparison, secondary medical care is the medical care provided by a physician who acts as a consultant at the request of the primary physician.

Also as the name implies, tertiary health care is the top most level of health care, which provides referral base for all cases sent from primary and secondary levels. Health institutions involved here are: specialist and teaching hospitals. This level also provides the mutually supportive referral sub-systems to the secondary care level and specialists with rehabilitation care as well as training for capacity building.

The tertiary level care is the responsibility of the federal government in Nigeria. This is because of the high financial commitment of the activities involved, such as specialist services, huge technology, advanced diagnostic procedures and counseling. The federal government therefore controls the tertiary level of health care in Nigeria through Legislation, policy making, standard setting, health manpower training provision of teaching committee, providing assistance to state and local government (Campbell 2007).

2.3 Theoretical Framework on Health Care Seeking Behaviour Among the Aged

The theoretical base approach to health care seeking behaviour have the potential to specific critical factors of target change, to suggest method for effecting changes and to guide us for evaluating health care seeking behaviour among the aged. Health psychology drawn upon a range of model in it approach , the model according to Naido and wills (2001), help us to understand peoples view about how people can explain their

health and ill health which is crucial in making sense of strategies that they adopt to promote health and make decisions, current model and theories help to explain human behaviour particularly as it relate to health education , these can be classified on the basis of being directed at the level of individual (intrapersonal) interpersonal or community. For the purpose of this research health belief model will be used.

Health Belief Model

This theory explain psychological health behaviour change, the model is developed to explain and predict health-related behaviours, particularly in regard to the uptake of health services. The health belief model was developed in the 1950s by social psychologists at the U.S. Public Health Service (Janz, Nancy K.; Marshall H. Becker 1984, Rosenstock, Irwin 1974) and remains one of the best known and most widely used theories in health behaviour research. (carpenter, christopher 2010 , Glanz, karen, Bishop, donald 2010) The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behaviour. (Janz, Nancy K.; Marshall H. Becker 1984, Rosenstock, Irwin 1974) A stimulus, or cue to action, must also be presented in order to trigger the health-promoting behaviour. (Janz, Nancy K.; Marshall H. Becker 1984, Rosenstock, Irwin 1974), explain that below are the theoretical construct to understand the health seeking behaviour of the individual person;

Perceived Severity on Health Seeking Behaviour

Perceived severity refers to subjective assessment of the severity of a health problem and its potential consequences.' (Janz, Nancy. Marshall. Becker 1984, Glanz, Karen; Barbara . Rimer, and Viswanath 2008). The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in

behaviours to prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles.(rosenstock, irwin 1974, janz, nancy marshall, becker 1984, Glanz, Karen Barbara . Rimer. and Viswanath 2008) For instance, the aged individual may perceive that arthritis is not medically serious, but if he or she perceives that there would be serious consequences as a result of lack of treatment for several days, then he or she may perceive arthritis to be a particularly serious condition.

Perceived Susceptibility on Health Seeking Behaviour

Perceived susceptibility refers to subjective assessment of risk of developing a health problem.' Janz, Nancy. Marshall Becker 1984, Rosenstock, Irwin 1974, Glanz, Karen; Barbara. Rimer. and Viswanath 2008).The health belief model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviours to reduce their risk of developing the health problem.(Rosenstock, irwin 1974), Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular illness. (Rosenstock, Irwin 1974), Others may acknowledge the possibility that they could develop the il1nes but believe it is unlikely. (Rosenstock, irwin 1974) Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviours. Individuals who perceive a high risk that they will be personally affected by a particular health problem are more likely to engage in behaviours to decrease their risk of developing the condition. The combination of perceived seriousness and perceived susceptibility is referred to as perceived threat. (Glanz, Karen; Barbara. Rimer and Viswanath 2008) Perceived seriousness and perceived susceptibility to a given health condition depend on knowledge about the condition. Rosenstock, irwin 1974) ,The health belief model predicts that higher

perceived threat leads to higher likelihood of engagement in health-promoting behaviours by the aged.

Perceived Benefits on Health Seeking Behaviour

Health-related behaviours are also influenced by the perceived benefits of taking action. *(*Glanz, Karen; Barbara. Rimer. and Viswanath 2008*)* Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease.(Janz, nancy, marshall, becker 1984), If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action. (Rosenstock, irwin 1974) For example, the aged individuals who believe that exercise can prevents diseases such as cardiac attack more likely to practice healthy behaviour than aged individuals who not believe.

Perceived Barriers on Health Seeking Behaviour

Health-related behaviours are also a function of perceived barriers to taking action.(Glanz, Karen, Barbara, Rimer, Viswanath 2008) Perceived barriers health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour. In other words, the perceived benefits must outweigh the perceived barriers in order for behaviour change to occur.'(Janz, Nancy, Marshall Becker 1984, Glanz, Karen; Barbara. Rimer; and Viswanath 2008) Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a medical procedure) and discomfort (e.g., pain, emotional upset) involved in engaging in the behaviour. (Rosenstock, irwin 1974) For instance, lack of access to affordable health care by the aged and the perception that ageing period do not require medical aid will cause significant harm and act as barriers.

Modifying Variables on Health Seeking Behaviour

Individual characteristics, including demographic, psychosocial, and structural variables, can affect perceptions (i.e., perceived seriousness, susceptibility, benefits, and barriers) of health-related behaviours. (rosenstock, irwin 1974), Demographic variables include age, sex, race, ethnicity, and education, among others.(Rosenstock, irwin 1974, Glanz, Karen; Barbara . Rimer. and Viswanath 2008). Psychosocial variables include personality, social class, and peer and reference group pressure, among others. (Rosenstock, Irwin 1974) Structural variables include knowledge about a given disease and prior contact with the disease, among other factors. (Rosenstock, irwin 1974), The health belief model suggests that modifying variables affect health-related behaviours indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers.(Rosenstock, irwin 1974, Glanz, Karen; Barbara. Rimer. and Viswanath 2008). The aged person health is likely to be affected by his or are education or culture such people sometime find it difficult to attain some basic health service due to such factors

Cues to Action on Health Seeking Behaviour

The health belief model posits that a cue, or trigger, is necessary for prompting engagement in health- promoting behaviours of an individual. (Janz, Nancy, Marshall, Becker 1984,rosenstock, Irwin 1974, carpenter, Christopher 2010) Cues to action can be internal or external. (Janz, Nancy, Marshall, Becker 1984, carpenter, Christopher 2010) Physiological cues (e.g., pain, symptoms) are an example of internal cues to action.(Janz, Nancy, Marshall, Becker 1984,Glanz, Karen; Barbara K. Rimer; K. Viswanath 2008,) External cues include events or information from close others,(Janz, Nancy, Marshall, Becker 1986) the media,(Christopher, Irwin 2010) or health care providers (Janz, Nancy, Marshall, Becker 1986) promoting engagement in health-related behaviours. Examples of cues to action include a reminder postcard from a dentist, the

illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. (Christopher, Irwin 2010) For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened. The aged person require information relating to their health thus such information will assist a lot in preparing them to accept and practice regular health behaviour .

Self-Efficacy on Health Seeking Behaviour

Self-efficacy was added to the four components of the health belief model (i.e., perceived susceptibility, seriousness, benefits, and barriers) in 1988• *(*Glanz, Karen; Barbara . Rimer, Viswanath 2008, *Rosenstock, Irwin, Strecher, Victor, Becker,and Marshall 1988)* Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour. (Glanz, Karen; Barbara K. Rimer; K. Viswanath 2008) Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviours. *(Rosenstock, irwin, strecher, victor, becker, marshall 1988)* The model was originally developed in order to explain engagement in one-time health-related behaviours such as being screened for infection or receiving an immunization. (Christopher, Irwin 2010, *Rosenstock, Irwin, Strecher, Victor, Becker, Marshall 1988)*) Eventually, the health belief model was applied to more substantial, long-term behaviour change such as diet modification, exercise, and smoking. *(Rosenstock, Irwin, strecher, Victor, Becker, Marshall 1988)* Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-

efficacy) was a key component of health behaviour change. (Glanz, Karen; Barbara . Rimer; . Viswanath 2008, *Rosenstock, Irwin, Strecher, Victor, Becker, Marshall 1988)* .

Applications of Health Belief Theory on Health Seeking Behaviour among the Aged

The health belief model attempt to predict health behaviour through a variety of means, health is influenced by behaviour and behaviour is modifiable (Conner and Norman, 1996). According to MacKian (2003), the process of health care seeking involves identification of pathways to the formal health care system, often commencing with home care and traditional healers and extending to the formal system, pathways differing according to the present condition.

In a review of health belief model or theory, Tipping and Segall (1995) demonstrated that the decision to engage with a particular medical channel is influenced by a variety of variables, including sex, age, the social status of the aged, the type of illness, access to services and perceived quality of the service. Health-seeking behaviour looks at illness behaviour more generally and focus in particular on motivating factors of illness perception and health belief. Health care seeking behaviour Studies look beyond the individual for social patterns or determinants of decision making. Health seeking behaviour clearly varies for the same individuals or communities when faced with different illnesses. For example, Bedri (2001) highlights contrasting pathways to care for aged women when faced with abnormal vaginal discharge, as opposed to malaria. For the former, the woman is bound far more by rituals and obligations, such as shaving prior to examination, and being accompanied to a medical consultation by her husband.

The health belief model will be used to develop effective interventions to change aged health-related behaviours by targeting various aspects of the model's key constructs(susceptibility, severity, benefits , cue to action) (Christopher, Irwin 2010,

Rosenstock, Irwin M.; Strecher, Victor; Becker and Marshall. 1988) Interventions based on the health belief model may aim to increase perceived susceptibility and perceived seriousness of a health condition by providing education about prevalence and incidence of disease of the aged, individualized estimates of risks, and information about the consequences of aged related disease or illnesses (e.g., medical, fmancial, and social consequences). (Glanz, Karen; Barbara . Rimer; and Viswanath 2008) Interventions may also aim to alter the cost-benefit analysis of engaging in a health- promoting behaviour when seeking health care by the aged (i.e., increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy of various behaviours to reduce risk of disease, identifying common perceived barriers towards health care, providing incentives to engage in health-promoting behaviours, and engaging social support or other resources to encourage health-promoting behaviours among the aged persons. (Glanz, Karen; Barbara Rimer. and Viswanath 2008)

Furthermore, interventions based on the health belief model may provide cues to action to remind and encourage aged persons to engage in health-promoting behaviours such as practicing healthy aging. *(*Glanz, Karen; Barbara . Rimer. and Viswanath 2008*)* Interventions may also aim to boost self-efficacy by providing training in specific health-promoting behaviours, (Glanz, Karen; Barbara . Rimer; Viswanath 2008, Rosenstock, Irwin. Strecher, Victor . Becker, and Marshall . 1988) particularly for complex lifestyle changes in aged persons (e.g., changing diet or physical activity, adhering to a complicated medication regimen). (Rosenstock, Irwin. Strecher,Victor J.; Becker and Marshall 1988) Interventions can be aimed at the individual level (i.e., working one-on-one with aged individuals to increase engagement in health-related behaviours) or the societal level (e.g., through legislation, changes to the physical environment).(Stretcher, Victor Irwin. and Rosenstock 1997).

2.4 Health Care Seeking Behaviour Among the Aged

Okoye, (2011) is of the view that the health seeking behaviour of the aged is determined by their attitude and that the elderly sometimes focuses exclusively on him or herself and try to use power, pressure, influence or control in ways destructive to their relationship with their caregivers. To some extent, the elderly person's behaviour can be self-centred and not noticing other people feelings and not realizing when they are upset or when something you do upsets them. Occasionally, the elderly develop abusive behaviour. In this regard, they complain bitterly about unavoidable situations, finding faults with almost everything, blaming others for problems caused by themselves, refusing advice that would ease care tasks because they think that they know better and their ideas should be carried, prolonging conversations through repetition and demanding help beyond the caregiver's capacity. This invariably may induce stress.

According to Bennett, (2002), when seeking health care, the aged are liable to face situation such as mistreatment which has been identified in facilities for continuing care (such as nursing homes, residential care, hospitals and day care facilities) in almost every country where such institutions exist. Various people may be responsible for the abuse: a paid member of the staff, another resident, a voluntary visitor, or relatives or friends. An abusive or neglectful relationship between the older person and their caregiver at home may not necessarily end once the older person has entered institutional care; the abuse may sometimes continue in a new setting. A distinction must be made between individual acts of abuse or neglect in institutional settings and institutionalized abuse – where the prevailing regime of the institution itself is abusive or negligent. In practice, though, it is often difficult to say whether the reasons for abuse or neglect found in an institutional setting have been caused by individual acts or through institutional failings.

The spectrum of abuse and neglect within institutions spans a considerable range, and may be related to any of the following: The provision of care – for example, resistance to changes in geriatric medicine, erosion of individuality in the care, inadequate nutrition and deficient nursing care (such as lack of attention to pressure sores). Problems with staffing – for example, work related stress and staff burnout, poor physical working conditions, insufficient training and Psychological problems among staff. Difficulties in staff–resident interactions – for example, poor communication, aggressiveness on the part of residents and cultural differences, Environment – for example, a lack of basic privacy, dilapidated facilities, the use of restraints, inadequate sensory stimulation, and a proneness to accidents within the institution.

Abusive Traditions

According to Harrington (2000), many existing traditions are abusive towards older women, including belief in witchcraft and the practice of abandoning widows. Ending these customs will require a high degree of collaboration among many groups, probably over a long period of time. To help this process: Advocacy groups, consisting of older people as well as younger people, should be formed at local, provincial and national levels to campaign for change. Governmental health and welfare programmes should actively seek to mitigate the negative impact that many modernization processes and the consequent changes in family structure have on older people. National governments should establish an adequate pension system, in all countries where it does not exist.

2.5 Awareness of Health Care Service Among the Aged Persons

It is not uncommon for people to fall sick and die of disease that can be easily prevented and treated, many communities do not have access to simple remedies of proven or aware of where the services are provided, many people fail to make

appropriate use of them, individuals and communities often lack the awareness and essential knowledge on how to keep healthy, how to recognize hazardous situation in the environment and how to mobilize resource to solve health problem, one of the basic problem is the health service provision and management. Umar, Sanusi, Sokoto, & Hassan (2014), observe that health service management is a process of mobilizing and developing resource for the efficient provision of health service management, environmental health system promote awareness of health care service such as, the socio-cultural –norms, belief, attitudes and practice of the people, social infrastructure; road, housing, availability of water, educational strength, health services all within the reach of the individual, the population geography dissension or settlements demographic characteristic, political environment; political ideology, political orientation, political climate, economic environment, government policy, legal and regulatory environment.

Eze (2011) opines that awareness and provision of health care services for the elderly has not been the priority to successive government in Nigeria, according to him, that the 6th senate has passed a bill for an acts to establish a national center from elderly persons for general propose of providing welfare and recreational facilities for the elderly and the designing of developmental programmes and activities for the advancement of elderly in Nigeria, the bill sponsored by senator Ganiyu Solomon was passed in July 14 2009. Another similar bill sponsored by Senator Anyin Ude in June 2010, the bill titled An act to provide social security for unemployed graduate and the aged in Nigeria for purpose connected thereto. Eze (2011) asserts that the bills were never implemented and for the elderly to be aware of health care services, training and engagement of social workers to publicize government implemented policies for the aged and where and when to receive health care services made for them, formulation of a state policies on the care for the elderly , national policy on the care and welfare of the elderly,

health service centre should be located within the reach of the aged and that will create awareness on services available to them for use.

2.6. Practice of The Aged Persons towards Health Care

Lecovich, & Biderman, (2012), report that use of day care centres led to lower emotional stress and attenuation of strain between caregivers and elderly parents. They also note that the use of adult day care centers assist with the growing and stressful demands that are placed on caregivers. According to Valadez, (2005), the knowledge that an elderly relative is in a safe and structured environment when he/she is at work leads to less stress on the part of the care giver. In his own contribution, Ron (2007),states that regular attendance at adult day care centers contributes to the increased level of self esteem among elderly women who are functionally limited both in their sense of mastery of life and situation, as well as in their self-evaluation. Lee, (2012) states that day care centres helps in exchange of information among the elderly.

According to them, active exchange of information and experience and development of networks help elderly persons to learn about the happenings in the community. All these advantages and many more should spur policy makers towards considering establishing these neighborhood adult day care centres. Be so in Nigeria, as there has been few or no programmes devoted to the elderly segment of the population (Asagba, 2005). Therefore, in response to the growing population of elderly person's there is a growing need for social services. One way of doing this is for the, Nigerian government to begin to consider adopting some of the community-based service model that exist in other countries.

Elderly persons, particularly the frail older adults, have been the most significant consumer of health resources (Young, 2003). Old people need health care because old age is associated with pain and ill-health (Hanks-Bell, 2004; Biswas, 2006)**.** Worldwide,

the increase in the proportion of elderly is in response to improvement in health technologies and life expectancy of people (Moe, 2012). According to Sharma, (2012), this rapid growth of the elderly population is a challenge to the medical profession, administration and the society as well. According to Umar, Sanusi, Sokoto & Hassan (2014) that many Nigerians do not benefit fully from modern technology that could have protected and resorted their health, therefore questions are rise in respect of health care, how can health service be organized to ensure that maximum from the current knowledge and available technology, for promotion, maintenance, and restoration of health? Ali (2014) assert that to enable health care practice for the older age, it is paramount that quality should be emphasized, quality in health care is a product of cooperation between patient and health care provider in a supportive environment, health care quality is the only means through which people will appreciate , accept, and practice optimal healthful living, according to Ali (2014) health care quality can be improved by supportive visionary leadership, proper planning , education and training of social workers and medical personnel, availability of resource, collaboration and cooperation among providers.

Quality health care is characterized by practice, while practice is characterized by availability of health care service, affordability of health care services, accessibility of health care service, appropriateness of health care services, acceptability of health care services, competency of service provider, reliability of the health care services and its comprehensiveness , continuity and equity in service provision, amenities and facilities should be in proper shape and ready to use at all time.

2.7. Health Problems Associated with Ageing

According to Aging Care (2015), the aging process itself also introduces many changes in normal bodily processes, these changes may range in severity and potential for harm, from fairly innocuous to mildly inconvenient to significantly troublesome. In addition, they can complicate other health problems and their treatment, some of these changes include;

1. Changes in liver and kidney function; these changes are complex but in general produce a slowdown in the rate at which these organs con process, excrete and clear certain substances, such as medicines, from the body, since standard dosage of medicines are based on how long they stay in the average person's body before they are eliminated, this slowdown in the older people's elimination systems means that those standard dosage could be way off and need adjustment.
2. Menopause and post-menopausal issues; the end of the reproductive cycle in women not only produce a number of uncomfortable side effect , but also has been shown to increase the risk factor for a number of health issues, including osteoporosis, certain kinds of cancer, and parkinson's disease, however some forms of hormone replacement therapy given to combat these risks and side effects have shown by some medical studies to raise risk of other health problems themselves, such as breast cancer and heart disease.
3. Changes in sleep pattern; as people age, they tend to have greater difficulty falling asleep, staying asleep and maintaining the deeper sleep cycles needed for full restful slumber, all of which can have significant effect on health and general wellbeing.
4. Changes in percent of body fat; this tend to rise with age, which can have consequences for cardiovascular health, also since many medicines are fat soluble and thus tend to persist in a person's body fat, an increase in body fat can interfere in

complicated ways with the dosage of medicines taken by older people. According to Alzheimer's and aging research centre (2011) , there are several classes of health issues that confront the elderly, some of them are chronic conditions:

1. Cardiovascular Disease; Heart disease is among the leading causes of death in many other countries. The most common form is coronary artery disease which involves a narrowing or blockage of the main arteries supplying the heart with blood, obstructions can develop over time, or quickly as in an acute rupture and cause potential fatal heart attack.
2. Cerebrovascular Disease (stroke); A stroke happens when blood stops flowing in one area of the brain because of a disruption in one of the blood vessels. It is very serious because brain cells deprived of oxygen in the blood begin to die very quickly, there are two types of stroke, the most common is called an ischemic stroke which occurs when a blood clot blocks a blood vessel, the second type is called a hemorrhagic stroke and is caused when a blood vessel ruptures and bleeds in the brain, stroke can cause death or serious disability depending on the location and severity of the blockage or rupture.
3. High blood pressure- Hypertension; Blood pressure is the force blood exerts on the walls inside your arteries as your heart pumps. It's lower when you're sleeping or are at rest and higher when you're stressed or excited- though it tend to rise generally with age. Chronically elevated blood pressure can cause serious problem for the heart, blood vessels, kidneys and other systems in the body.
4. Cancer; one of the biggest risk factors for many types of cancer in which abnormal cells grow uncontrollably, is age, According to American cancer society (2010), 77% of all cancers are diagnosed in people over the age of 55, the number of types

of cancer are common as we age, including skin, breast, colorectal, prostate, non-Hodkin's lymphoma and stomach cancer.

5. Type 2 Diabetes; Diabetes is a disorder that erupts the way your body uses glucose, or sugar, from the food it digest. In diabetes 1, which typically begins in people under the age of 30, no insulin is produced. The far more common Type 2 diabetes involve insufficient insulin but an acquired resistance to it so glucose is not processed properly by the body. Both types of diabetes lead to blood sugar levels that are too high, which can lead to serious problems like heart attack, stroke, nerve damage, kidney failure and blindness.
6. Parkinson's Disease; named after the British physician who first described it in early 1800s, this progressive neurological disorder causes tremor, stiffness and halting movement. Three quarters of all cases of Parkinson's disease begin after the age of 60, though age is only one risk factor. Men are more likely than women to get Parkinson Disease, as are people with a family history of the disease or those who have been exposed to certain chemical toxins, Head injuries may also play a role.
7. Dementia (including Alzheimer's disease); characterized by a loss of brain functioning, dementia can manifest as memory loss, mood changes, confusion, difficulty communicating or poor judgment. Alzheimer disease is the most common cause of dementia, but there are a number of other causes, including vascular dementia (due to impaired blood flow to the brain).
8. Chronic obstructive pulmonary Disease (COPD); chronic obstructive pulmonary disease cannot be cured, but it can be treated, and perhaps more importantly prevented. The condition is characterized by reduction of airflow into and out of the lungs, thickening of the lining of the lungs and an over production of mucus in the air tubes, symptoms include a worsening chronic and productive cough, wheezing

and shortness of breath, the main causes of chronic obstructive pulmonary disease is chronic exposure to airborne irritants like tobacco smoke, occupational determinants or industrial pollution. Cigarette smoking remains the most significant risk factor.

9. Osteoarthritis; osteoarthritis is a degenerative joint disease and the most common form of arthritis. Osteoarthritis occurs more commonly as people age and it's more prevalent in women being obese or having had a prior joint injury also makes you more susceptible. It is characterized by swelling and pain in the joint. It can be managed if one adopt a good life style like weight loss, exercise and physiotherapy.
10. Osteoporosis; also known as brittle diseases, it is characterized by bone mass loss which leads to thinning and weakening bones. It gets more common with age, regular weight bearing exercise, eating a diet rich in calcium and vitamin D can help prevent osteoporosis.

2.8 Utilization of Health Care Services and Support for the Aged Persons

Aging will demand a greater support of some health related services that will enhance their quality of living, this serve a great importance for their existence , this services and support include the followings;-

1. Social Support and Health:-

Meaningful social relationships provide a sense of security and opportunities for companionship and intimacy which are important for the well being of older people (McNicholas, 2002; Fajemilehin, 2009; Giang and Dfau, 2009). Those who provide social supports give advice about health practices, disease prevention and encourage the practice of positive health behaviour. This means that social support can influence specific health behaviour such as diet, exercise, compliance with medical regime, smoking, drinking of alcohol by providing information about positive health practices

and by establishing norms that will encourage good health behaviour. (McNicholas, 2002; Fajemilehin, 2009; Giang & Dfau, 2009).

In Africa, there was cultural respect and acceptability for the elderly. During the period, the elderly subgroup practiced traditional farming system and polygamy as the vogues of wealth and survival, and hence, enjoyed a level of social support as the relational provision of attachment, social integration, opportunity to nurture, feeling of worth, sense of reliability and guidance which has contributed to quality of life of the elderly in the sub region. Also of concern is the increasing record from the central, south and east Africa that elderly persons are subjected to various level of abuses rather than being cared for. The aforementioned scenario is unlike what obtains in Japan and Sweden, where the culture of family care and support for the elderly are still not only maintained but improved upon by all and sundry, A positive number of findings/ researchers (HelpAge, 2002; Fajemilehin, 2001, 2009; Giang & Dfau, 2009; Kelley, 2005; Shamas, 2003) had suggested that social support is antecedent to cultural values, health behaviour and positive health practices.

Although those aged 60 years and above represent a relatively small fraction of the population of Nigeria, they constitute about 6% and are expected to increase significantly to between 12 to 15% between now and year 2015 (WHO, 2002; Fajemilehin, 2009; Giang & Dfau, 2009). Nigerian society however, like many other developing nations has paid little or no attention to this sub- group of the society. Because of lack of formal structure of care and social support networks, in this part of the world older men and women are largely dependent on the informal traditional family support system and which today has become weakened (Fajemilehin, 2001).

2. Caregivers Services and Support-

Providing care to someone especially the elderly whether full time, part time, formal, informal or long distance takes a huge toll, both physically and emotionally. Few people are prepared for the responsibilities and tasks involved in caring for the aged because of the stress involved in It, Vitaliano, (2003) and Lecovich, (2008) state that caregivers provide many kinds of help to the care receivers ranging from assistance with shopping to help with daily task such as bathing, dressing, feeding, lifting, turning him or her in bed,cooking shopping, paying of bills, running errands, giving medicine, keeping him or her company, providing emotional support and so many other things. All these help rendered by caregivers can be time consuming and emotionally, physically and psychologically draining. This then contributes a lot of stress on the caregivers meanwhile Care giving can create positive feelings. Losada,(2009).

3. Utilization of Health Facilities-

According to Centre for Technology and Aging (2009), Technologies that assist in the care of chronic conditions and improve the independence of older adults can cover a very wide spectrum, including communication, assistive, telemonitoring, telehealth and other technology-enabled services,Technologies that extend the ability to provide care for persons with chronic illness have been increasingly successful in improving the well-being and independence of older adults, the segment of our population that has the greatest demand for health and long-term care services. These technologies offer a means of reducing the burden of chronic care for patients, families, and the health care system as a whole, while improving older adults' safety, health/well-being, and social interaction. However, for these technologies to realize their potential to improve the efficiency of health care delivery, reduce the costs of health care, improve health care outcomes, and most importantly, maximize the independence and quality of life of older

adults, these technologies must be rapidly expanded to scale in home and community-based care settings, seven technology domains were identified as high priority candidates for rapid diffusion. This process included an assessment of the experience of early adopters and the viability of each technology. After review of the seven areas of technology, two priority areas were found to be indispensable, medication optimization and remote patient monitoring, (Centre for Technology and Aging, 2009).

1) Medication Optimization refers to a wide variety of technologies designed to help manage medication information, dispensing, adherence, and tracking. Technologies range from the more complex, fully integrated devices that use information and communication technologies to inform and remind stakeholders at multiple decision and action points throughout the patient care process to the simpler, standalone devices with more limited functionality, (Centre for Technology and aging, 2009).

2) Remote Patient Monitoring (RPM) includes a wide variety of technologies designed to manage and monitor a range of health conditions. Point-of-care (e.g., home) monitoring devices, such as weight scales, glucometers, and blood pressure monitors, may stand alone to collect and report health data, or they may become part of a fully integrated health data collection, analysis, and reporting system that communicates to multiple nodes of the health system and provides alerts when health conditions decline, (Centre for Technology and Aging, 2009).

3) Assistive Technologies- Cooper (2008), include a wide range of devices and equipment that help individuals perform a task or prevent injury. Assistive technologies promote independence as they compensate for sensory, physical, and cognitive impairments, and promote safety for vulnerable individuals as they detect and report health hazards. Non-computer-based assistive technologies include items such as wheelchairs, grab bars, Braille, and a more accessible home environment. Examples of

computer-based technologies include voice recognition software, and monitoring and alert systems that detect and report environmental hazards or personal crises.

4) Remote Training and Supervision (RTS); According to Barrett, (2008) ,technologies can be used to train and supervise health and long-term care workers, and offer the potential for continuing education and quality assurance. Remote training means the student does not have to be physically located where the teaching is taking place – teaching and learning can be asynchronous or synchronous in time. Access to training is gained through technologies such as the Internet, interactive videoconferencing, and satellite. Examples of remote training include a distance learning course, a simulation exercise, and a video-guided practicum. RTS technologies are also useful in the ongoing supervision of workers, particularly low-skill workers, and for on-demand consultation with more experienced supervisors or instructors. In many cases, these or similar approaches may also be used to train and support informal caregivers, Barrett, (2008) i.e., family members.

5) Disease Management (DM)- Matheson, (2006),states that it is a patient-centric, coordinated care process for patients with specific health conditions, particularly chronic conditions and conditions that have a significant self-care component. DM programs include data mining processes to identify high risk patients within a population, use of evidence-based medical practice guidelines to support and treat individual patients, and a coordinated, data-informed system of patient outreach, feedback, and response.

6) Cognitive Fitness and Assessment technologies include thinking games and cognitive challenge regimens. Like physical fitness, the premise of cognitive fitness is that cognitive health can be maintained or improved if individuals exercise their brain. The emphasis with older adults is to prevent or delay Alzheimer's and related dementias.

Many cognitive fitness technologies are computer or Internet based, and include an assessment and tracking component. Sharp,(2009).

7) Social Networking technologies enable the creation of social networks and focus on building communities of interest that help older adults communicate, organize, and share with other older adults and with their care providers. These are already gaining traction among older adults, and could be important both for the functions just described and for peer counseling and education that would complement the Remote Training and Supervision technologies described previously. Sarasohn, (2009).

As health care delivery and long-term care evolve, evidence will continue to emerge regarding the viability of new technologies and their contribution to the health and well-being of older adults although Many technologies have the potential to simultaneously help older adults remain in their homes as long as possible and mitigate the workforce shortages and financial burdens that are inherent to long-term care.

8) Clinical Preventive Services; According to Centre for Disease Control (CDC 2005), Clinical preventive services which include immunizations, screening tests and counseling to prevent the onset or progression of disease and disability – are important tools to maintain the health of older adults. These preventive services – primarily delivered in a clinical setting – are an important component of the National Prevention Strategy. Released by the National Prevention, Health Promotion, and Public Health Council in June 2011, the National Prevention Strategy is a comprehensive plan to help increase the number of aged who are healthy at every stage of life. Clinical preventive services can help lower health risks and costs of treating chronic disease, as well as prevent or delay the onset of disease. The Guide to Community Preventive Services (Centre for Disease Control, 2005) developed by the Task Force on Community Preventive Services, clinical guidelines, and numerous studies call for routine preventive

services for older adults – and Medicare covers many of them – yet gaps remain in the number of older adults receiving recommended services, Health and Human Services (HHS 2011).

These gaps are greater for certain populations who are socially, economically and/or environmentally disadvantaged (Tebo, 2011). Low-income and ethnic and racial minorities, as well as people who live in rural or remote areas, are less likely to receive these services than the overall population, Agencies for Health Care Research and Quality (AHRQ 2010, AHRQ 2009). Ensuring that all adults have access to and receive recommended clinical preventive services such as immunizations and screenings for chronic conditions should be a cornerstone of our public health efforts to promote health and prevent disease, Lynda, (2012). It is always better to catch and treat an illness earlier rather than later, and clinical preventive services enable us to do that, (Douglas, 2012). Clinical preventive services can help prevent chronic disease, reduce associated complications and lower functional limitations (Cohen 2009, Maciosek 2010). "Clinical preventive services usually save money, although that isn't the only rationale for them, because they also can prevent illness or shorten the course of illness," explained Wallace, (2012). Older adults who obtain clinical preventive services and practice healthy behaviours are more likely to remain healthy and functionally independent It is always better to identify and treat an illness earlier rather than later, and clinical preventive services enable us to do that, (Cranksaw 2002, CDC 2011).Clinical preventive services can be important in three stages , Doug, (2001). These are:

1) Before disease occurs (for example, vaccinations);

2) Before disease is clinically evident (for example, breast cancer screening); and

3) Once disease is established but before it has made its maximal impact (such as vision screening for eye diseases in persons living with diabetes).

According to interim management and support (2012) for effective provision of quality health care service for the aged, approach for urgent and emergency care are paramount which are-

i. Involving Social Services Care Management

Ensure there is a social service input into the on-site multi-disciplinary team for complex discharges and that assessments are not delayed until a patient is deemed 'medically fit'. Work with partners to secure local agreement that all referral processes (e.g. for continuing health care) have been made as simple as possible (i.e. simple, short documentation that is quickly and easily completed). Allow simple, single-call processes for restarts of existing care packages for short-stay discharges. Ensure that for complex care packages, there is same or next day funding approval, *(Care Needs*, 2012).

Maximizing weekend discharges should be seen as a whole-system issue, requiring co-ordination between partners. Ensure the availability of social workers, NHS community services and hospital therapists (particularly where they work across the hospital/community interface) matches any increased focus within an acute trust on weekend discharges. *Care Needs*, (2012).

ii. **Standards in Community Hospitals**

Ensure community hospitals work to clear operational standards regarding discharge, including using consultant-approved care plans, expected discharge dates and clinical criteria for discharge. Local systems for reviewing prolonged stays are particularly important. Patients should not remain in community hospital beds where pathways exist for them to be cared for in their own homes.

Similar standards of early and proactive discharge plannings should apply in community hospitals as in acute care – and be monitored and specified by commissioners. Good practice is that social services' standards in community hospitals for time to undertake assessment should mirror the three-day Section 2 time-frame in acute settings interim management and support (2012).

iii**. Seek Feedback on Patients' Discharge Experiences**

Ensure regular patient and carer feedback is sought about discharge arrangements, Patient and Carer, (2010). Encourage community services to highlight any concerns about the quality of an acute hospital discharge. Clarify expectations about how long responses should take and how mutual learning will be shared and spread.

iv. Priorities dementia care

Adopt a philosophy that seeks to manage people with dementia assertively, with risks identified and managed, rather than compounded by even short-term hospitalization. Promote staff awareness about dementia care in acute hospitals, David, (2010). Poor recognition and response by staff increases the risk of a damaging patient experience and significantly longer lengths of stay across medical and surgical specialties. Alzheimer's Society (2009). Promote cultural change using key themes: developing a psychiatric liaison service; documentation that encourages consideration of cognitive impairment, Alzheimer's Society (2009) ; staff awareness training; dementia-friendly environmental changes; a common assessment tool; nutritional support; and appropriate ward-based activities, like reminiscence. Use the national audit for dementia care in general hospitals to measure progress.

v. **Care home support**

Undertake an audit of patients admitted to hospital from care homes as emergencies. This will help identify themes about how the risk of admission can be

minimized and enable the design of advanced care planning with an appropriately skilled response. Develop programmes to enhance specialist input to and competences within care homes. Patient and carer, (2010).

Home and Community Care Active Service Model

The Home and Community Care (HACC) Active Service Model is a quality improvement initiative that focuses on restorative care and on promoting capacity building in community care service delivery, Broad Policy Context (2005), which emphasized early intervention and prevention in all services and for older people, helping them to 'stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy. Thegoal of the Active Service Model is to assist people in home and community care target group to live in the community as independently and autonomously as possible.

2.9 Strategies for Promoting Healthy Ageing

According to Lee, Cigolle, & Blaum (2009) the common occurrence of both age-related syndromes and chronic diseases among older people suggests the need to integrate health care and management of these conditions. Comprehensive care guidelines and quality indicators offer coordinated management of coexisting chronic diseases and age related syndromes. A novel, community-based comprehensive prevention program for older people in the USA using 10 preventive health goals, education and counselling, showed improvements in adherence to preventive health activities such as vaccination, cancer screening and target goals for cholesterol, blood pressure and blood glucose (Newman, 2006).

According to National Ageing Research Institute (NARI) and Council on the Ageing (COTA) for the Victorian Department of Health (2012) states that there are three basic strategies for promoting healthy ageing which are;

1. Self-management
2. Medication management
3. Health literacy

Self-management can be defined as;

- engaging in activities that promote health, build physiologic reserve
- interacting with health care providers and adhering to recommended treatment protocols
- monitoring physical and emotional status and making appropriate management decisions on the basis of the results of self-monitoring
- managing the effects of illness on the patient's ability to function in important roles and on emotions, self-esteem, and relationships with others.

Chronic Disease Self-Management (CDSM) programs are developed to introduce and educate participants to the core elements of self-management, such as problem solving, decision making, resource utilization, forming partnerships with healthcare providers and taking action (Lorig, & Holman, 2003). Chronic Disease Self-Management can cover specific health conditions or chronic disease risk prevention in general. There are different ways of delivering effective Chronic Disease Self-Management programs but research evidence predominantly comes from face-to-face group setting delivery (Chodosh, 2005). Despite the majority of Chronic Disease Self-Management evidence being derived from osteoarthritis, diabetes and hypertension are the two chronic conditions that have shown significant health improvement (Chodosh, 2005, Warsi, 2004).

Risk factors attributable to diabetes and hypertension are interrelated including poor nutrition, high blood pressure, physical inactivity, tobacco smoking, alcohol abuse, and overweight/obesity.

The key principles behind self-management are that

- illness management skills are learned and behaviour is self-directed
- motivation and self-confidence (or self-efficacy) in management of illness are important determinants of patients' performance of self-care
- monitoring and responding to changes in disease state, symptoms, emotions, and functioning improves adaptation to illness, (Centre for Disease Control, 2003).

National standards were established in the USA to provide ways to deliver effective education in Chronic Disease Self-Management (Funnell, 2007). Programs incorporating behavioural and psychosocial strategies demonstrate improved outcomes as do culturally and age-appropriate programs and group education. The review also state that ongoing support is critical to sustain progress of participants and that behavioural goal setting was an effective strategy. There are different types of self-management programs including lay-led or peer-led, health professionals-led, a combination of peer and health professional-led and self-management support which is provided by health care and community services.

There are also different ways to deliver self-management programs including face-to-face, over the telephone and online. The most common self-management programs are delivered in a small group setting, for example, the Stanford self-management program (Holman, & Lorig 2004). There are limited programs that specifically target older people. A review article on self-care programs available for older people with long-term conditions show that the majority of the programs were patient education delivered in a group setting by health professionals (Berzins, 2009). This review found significant improvement in physical and illness functioning and self-efficacy due to participation in these self-care programs.

A Cochran Systematic Review on lay-led self-management education programs show small and short-term improvements in participants' self-efficacy, self-rated health, cognitive symptom management, and frequency of aerobic exercise (Foster, 2007). The Healthy Changes peer education program reports significant improvement in diet and physical activity among older people who were either overweight or obese and suffered from multiple chronic conditions (Klug, Toobert, & Fogerty 2008). Most self-management programs have a single disease focus due to the different nature and progression of the disease. Overall, the self-management programs produce a small to moderate effect size.

Among people with arthritis, self-management programs produce small effects with potential improvement in certain cognitive-behavioural markers and functional gains (Nunez, Keller, & Ananian, 2009). Self-management education for people with Chronic Obstructive and Pulmonary Disease (COPD) is associated with reduced hospital admissions (Effing, 2007). Among people with heart failure, cognitive-behavioural intervention is commonly used to improve people's heart failure self-care (Effing, 2007 Effing, 2007). Most studies in this review found significantly higher levels of knowledge pertaining to heart failure and heart failure related self-care (Barnason, Zimmerman, &Young, 2012). Intensive self-management interventions reduced emergency department visits and hospitalizations while intensive self and disease-management interventions reduced disease severity (Sheridan, 2011).

Medication Management for Healthy Ageing

There are some benefits of certain interventions in reducing inappropriate prescribing and medication-related problems (Patterson, 2012). Another review to reduce inappropriate prescribing in older people found that computerized support system interventions produced significantly improved prescribing and dispensing practices

regularly (Kaur, 2009). Medication use among older people is complex. There are many facets to consider including age-related changes and multiple chronic conditions. Medication use should be tailored to individual needs and requires collaboration from the health care industry, physicians, pharmacists, nurses, care givers and older person, and support from the health care system and regulatory authorities (Stegemann, 2010).

Health Literacy for Healthy Aging

People with low health literacy levels face barriers in accessing care because the written materials provided to them are produced above the National Health Literacy Level (Cutilli, 2007). Schillinger (2003) found that people with diabetes with low health literacy who were advised by a physician using an interactive communication strategy were able to manage their diabetic symptoms better. The key elements of this interactive communication strategy were to ask people to restate new information or instructions to ensure these were remembered or to assess peoples' perceptions about new information that had been delivered to them. A review on addressing low health literacy found evidence around the use of multiple discrete design features that include (Aalbers, Baars, &Rikkert, 2011):

- presenting essential information by itself or first
- presenting information so that the higher number is better
- adding icon arrays to numerical information
- adding video to verbal narratives.

Many older people have begun to seek health information online. Evidence around the effectiveness of interventions to improve consumers' online health literacy (including skills to search, evaluate and use online health information) is still lacking mainly due to small number of studies published to date (Car, 2011).Victorian Quality Council (2012), stated that other strategies for promoting healthy ageing are;

Healthy Eating for Healthy Aging

According to WHO Technical Report Series (2003) states that Reducing overweight can also reduce the nutritional risk factors for chronic disease With respect to cognitive decline these include:

- Reducing the intake of saturated and trans-unsaturated (hydrogenated) fats (positively associated with increased risk of age-related cognitive decline and mild cognitive impairment and Alzheimer's disease).
- Increasing the intake of polyunsaturated and monounsaturated fats (protective against cognitive decline in older people in prospective studies).
- Increasing fish consumption.
- Ensuring adequate intake of B-vitamins, especially vitamins B9 (folate) and B12, on cognitive decline and dementia.
- Results on antioxidant nutrients are more mixed, suggesting a need to balance the combination of several antioxidant nutrients to exert a significant effect on the prevention of cognitive decline and dementia to avoid any adverse effects caused by overdosing on some.
- Securing adequate intake of fruit and vegetables as a source of protective antioxidants against cognitive decline, dementia and Alzheimer's disease.
- Keeping alcohol use to a moderation. Light-to-moderate alcohol use may be associated with a reduced risk of incident dementia and Alzheimer's disease, while for vascular dementia, cognitive decline and pre-dementia syndromes, the current evidence is only suggestive of a protective effect, The above recommendations are in line with the WHO dietary guidelines (*WHO, 2003*) for the reduction in overweight and obesity by achieving energy balance and a healthy weight, reduction of chronic illness by limiting energy intake from total fats and

saturated fats and eliminating trans-fatty acids from the dietary sources, increasing the consumption of fruits and vegetables, legumes, whole grains and nuts, and limiting the intake of free sugars and salt (sodium).

These guidelines refer to all ages, however, as noted in the previous section, some caution should be exercised with adults over the age of 60 and 70 years (depending on the study) (Moss, 2012, McLaughlin, 2011). Reducing salt consumption from the current levels of above 18 g per day closer to the recommended level (varying by country from 5 to 8 g per day), will lead to lower blood pressure levels resulting in significant health benefits (Webster, 2011). Centrally implemented national salt reduction strategies involving all stakeholders and with monitoring and regulatory systems in place are projected to be highly cost-effective in the prevention of chronic diseases (Ma¨nnisto, 2010).

Bone Health for Healthy Aging

Bone fractures can be prevented by adequate calcium intake and weight-bearing exercise, plus daily 15 minute exposure to sunlight or supplementing the diet with vitamin D, provided the nutritional intake is otherwise adequate. Although bone health is established early in life, it needs to be upheld throughout the life course, and can be improved and maintained till late in life reducing salt (sodium) intake can provide protection against fractures as high intake of salt has been associated with osteoporosis.

Malnutrition in Care Settings

Adults aged 65 years and over living in care settings can be at risk of malnutrition which highlights the vulnerability of this group of older people and the need for routine nutrition screening and targeted intervention programs (Rist & Karimi 2012). Multilevel approaches such as the Victorian Well for Life health promotion intervention (McKenzie, Naccarella, & Thompson 2007) are promising in successfully addressing the

nutrition-related issues faced by the community nursing services providing home nursing care. An evaluation of this program indicates that over two-thirds of the participants had good to very good nutritional intake from a food variety perspective (Department of Health Melbourne, 2010).

Food Safety for Promoting Healthy Aging

Although older people generally require proper and safer food handling practices than younger people, they are more susceptible to food-borne illness and the related complications due to age-related weakening of resistance to infection (Lund, & O'Brien, 2011, Redmond, & Griffith, 2003). Food safety may also become a concern with older people due to pooreye-sight, memory or other reduction of sensory capacity. Older people affected by malnutrition are naturally more susceptible to food-borne illness. Good nutritional status helps fight the infection, but prevention is the key (Lund, & O'Brien, 2011). In a review of food-borne illness, Lund & O'Brien (2011) point out that diets for vulnerable people in care should exclude higher-risk foods, and vulnerable people in the community should receive clear advice about food safety, in particular avoidance of higher-risk foods and substitution of safer, nutritious foods'.

Food safety education delivered to older adults has been shown to change food safety practices, as illustrated in a program conducted at congregate meal sites (Sellers, Andress, &Johnson 2006).In terms of prevention, food safety training is required at all levels in the community, including at-risk groups such as older adults. Food safety information and educational material is now available online, which may give opportunities for intergenerational learning with interactive computer technology (Higgins, & Murray, 2010). However, the success of a web-based educational intervention among older people was not very encouraging, and the authors recommend printed materials and personal contact .Food safety strategies should also include

industry-led approaches to safer and user-friendly packaging with solutions that can provide longer shelf-life and more suitable portion sizes (Institute of Medicine (US) Food Forum, 2010).

Improving the Meals Offered to Promote Healthy Aging

In Western countries an increasing proportion of meals are being eaten outside of the home, in restaurants, schools and from take-away stores (Lachat, 2011). Studies have shown that frequent consumption of unhealthy and unbalanced take away meals is linked with overweight and obesity. From a healthy ageing perspective this development raises expectations as to the quality of food served. As older people are in large numbers among those who go 'out to eat', the quality of food served should be scrutinized, improved and monitored. The accessibility and availability of balanced meal options is all the more important when choice of restaurants is limited due to personal circumstance. Multi level approaches are required to encourage caterers to set new trends and reorient their business to prepare and promote healthier choices; to educate the public via agenda change among educators and the mass media; and to ensure commitment by state and federal governments to offer training and support for the implementation, followed by monitoring of quality and fiscal action when necessary. As the proportion of food consumed outside of the home continues to increase, it is essential that the nutritional quality be improved (Lachat ,*FOOD-programme 2011*, Raulio, Roos, & Prättälä 2010).

Increasing Practical Skills to Promoting Healthy

Lack of cooking skills may be related to more frequent use of ready-meals, defined as meals requiring few or no extra ingredients and designed to replace the main course of a homemade meal (van der Horst, Brunner, & Siegrist 2010). Ready meals are typically high in energy, fat, salt and sugar, and have inadequate amounts of vegetables,

and have been associated with overweight. More attention should be given to the composition of ready meals and the ways in which more vegetables could be included with such meals when served at home. Overall, there is increasing evidence on the negative effects of the transition away from home cooking: an Australian research team (Chen, 2012) has shown how adhering to home cooking can have a positive affection healthy ageing in a longitudinal study in Taiwan. Tailored cooking skills in intergenerational settings with interactive computer technology may prove useful (Kaplan, Kiernan, & L. James, 2006).

Healthy Eating Programs to Promote Healthy Aging

There is a strong tendency for health promotion activities relating to nutrition to focus on children—although there are some that do focus on older adults (Savage, & Bailey 2004). A recent review found that there is a paucity of evidence-based research on community nutrition interventions for older adults and few of these studies are well-designed or randomised with well-matched intervention and comparison groups. This review identifies innovative government healthy eating initiatives for older adults as well as programs and initiatives that have been implemented and evaluated for older adults in settings where they live. The evaluation methods of these programs tended to be based on self-reported habits and knowledge and not on more robust measures of nutritional outcomes. Using these evaluation methods makes it difficult to draw conclusions about the effectiveness of these programs for older adults, however, key findings and strategies used have been drawn out.

A recent review on nutrition education interventions for older adults found that many interventions tend to report limited success in behaviour change (Sahyoun, &Anderson 2004). Despite this finding there were certain features that had positive outcomes including: limiting education messages to one or two; reinforcing and

personalizing messages; providing hands-on activities, incentives, cues and access to health professionals; and using appropriate theories of behaviour change (Sahyoun, Pratt,&Anderson 2004). However, this review found that currently there is a paucity of intervention programs for older adults targeting nutrition. It was noted by these reviewers that before the question about whether nutrition education has a lasting influence on dietary behaviour, biochemical changes and ultimately health improvement and maintenance in older adults can be answered, we need to learn what constitutes well-constructed intervention programs for older adults and develop and evaluate these programs. The Eat Well Stay Well project aimed to promote key safety and nutritional messages for older people living at home through education talks given to older adults at various community centre locations (Food Vision 2007). In line with the research literature, the evaluation of the program found there to be only a marginal difference in nutritional knowledge at the end of the project indicating that the information the older adults had received had made little impact on healthy eating habits (Long, 2003).

Physical Activity for Promoting Healthy Aging

The National Physical Activity Recommendations for Older suggest that older people should be active every day in as many ways as possible; this includes doing a range of physical activities that incorporate fitness, strength, balance and flexibility. The programs were either run in community or residential aged care settings and the formats generally included multi-intervention approaches to increasing physical activity in older adults. These multi intervention approaches included combining various physical activity approaches (for example, aerobic, strength, balance and flexibility exercises) with education programs to empower individuals and promote individual skill development and behaviour change. The Home Support Exercise Program and Functional Fitness for Long Term Care Program both target the needs of a more at risk group of older adults

living at home or in long term care aiming to improve functional mobility through physical activity programs. The Home Support Exercise Program is an evidence-based program designed for frail older adults and delivered via the existing home care infrastructure in Canada (Johnson, 2003,). The Functional Fitness for Long Term Care Program, also from Canada, is tailored to meet the needs of high and low mobility residents in long term care homes. The evidence of these two programs was good (level 3-some evidence of effectiveness) and the evaluations show both programs to be cost-effective and improve physical function for the participants (Johnson, 2003). According to WHO (2002), one can remain active and fit when regular medical examination is considered to be part of daily behaviour and that active ageing is a process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age' allowing people to 'realize their potential for physical, social and mental well-being throughout the life course.

2.10 Empirical Studies on Health Care Seeking Behaviour

Odama (2014), conduct a study on health care seeking behaviour among the aged in Edo central Nigeria, the findings of his study reveal that majority of the elderly persons (62.7%) had age associated illnesses such as blood pressure, cardiac problems, diabetes, joint pains , kidney infections, cancer and tuberculosis that take a long time to heal. Precisely 73.7% of the elderly patronized the hospital/health centre whenever they fell sick. More elderly males than their female counterparts were found to have patronized traditional healers, resorted to self-medication using local herbs or visited chemist shop whenever they were sick. The researcher recommend that the elderly people should be provided free , accessible and comprehensive health care in hospitals and health centres because they would utilize the health services when available, accessible and affordable.

Ahmed et al (2004), conducted a study on socioeconomic status overrides age and gender in determining health seeking behaviour in rural Bangladesh, The focus is to study the health seeking behaviour of the elderly members (aged 60 years) of households in rural Bangladesh, his study reveal that there is no major differences in health seeking behaviour between elderly people and younger adults on average about 35% (405/1169) of those who reported having been ill during the previous 15 days in both age groups chose self-care /self-treatment, for both age group the most commonly consulted type of provider was a paraprofessional such as a village doctor, a medical assistant or a community health worker. A household's poverty status emerged as a major determinant of health seeking behaviour,

The researcher concluds that they found socioeconomic indicators were the single most pervasive determinant of health care seeking behaviour among the study population.

Menendez et al (2005), conducted a study on Health Seeking Behaviour in Northern KwaZulu-Natal, South Africa, the researchers examined patterns of health seeking behaviour prior to death among 1282 individuals who lived in the Umkhanyakude District of Northern KwaZulu-Natal. Information on the health care choices of these individuals, who died between January 2003 and July 2004, was gathered after their deaths from their primary care-givers. We examine choices made concerning public and private medicine, western and traditional medicine, and non-prescribed self-medication. The study reveals that virtually all adults who were ill prior to death sought treatment from a Western medical provider, visiting either a public clinic or a private doctor. In this district, which is predominantly poor, ninety percent of adults who sought treatment from a public clinic also visited a private doctor. Fifty percent also sought treatment from a traditional healer, suggesting that traditional medicine is seen as

a complement to, rather than a substitute for, Western care. Better educated people who were ill for less than a month before dying were significantly more likely to visit a private doctor, while those least well educated were more likely to visit a traditional healer. Controlling for length of illness, better educated and wealthier people sought care from a greater range of providers, and spent significantly more on their treatment.

Okumagba (2011), conducted a study on Family Support for the Elderly in Delta State of Nigeria The study reveals some of the major emphasis in the present study include the sources of support received, the forms of support received, frequency of support received, how adequate are supports received by the elderly, the relationship between the number of wives and children, social distance and the support received by the elderly, the study was carried out on the elderly in six urban centres and twelve villages in Delta State. People who are 60 years and above were considered as elderly for the purpose of the study. A total of 90 and 30 elders were selected from each urban and village respectively.

The primary data for this study was generated mainly through the use of a structured questionnaire which was administered with the help of undergraduate students of the Delta State University, Abraka who resided in the selected urban centres and villages. In addition to the use of structured questionnaire, the primary data was also generated through structured interviews and information talks with the elderly. The study also indicates that support received by the elderly are not regular and adequate. The study also established relationships between the number of wives, children and social distance and support received by the elderly in Nigeria.

Dawodu (2015), conducted a study on the investigation of Ageing and Health. A Comparative Study of Rural and Urban Aged Health Status in Bayelsa State, Nigeria. The survey study made use of 216 sampled sizes drawn from both the rural and urban

centres of Bayelsa state. The questionnaire served as the primary source of data collection. Findings from the study reveals that the aged in the rural areas suffer poorer health conditions than the aged in urban centres due to reasons ranging from poverty to unavailability of health care facilities. Recommendations of social support for the elderly, creating special wards for the elderly, should be emphasize.

2.11 Summary

The chapter has attempted to review essential areas such as conceptual , theoretical and empirical framework that are related to the present study to gain an insight into issues bordering the aged persons. In this chapter the related literature reviewed consist of Concept of aging, Concept of health care, theoretical framework on health care seeking behaviour among the aged, health care seeking behaviour among the aged persons, awareness of health care service among the aged persons, practice of the aged towards health care service, health problems associated with ageing, utilization of health care services and support for the aged persons, Strategies for promoting healthy ageing, empirical studies on health care seeking behaviour among the aged and health belief theory approach was used to back up the study along with it's various component such as self-efficacy, cue to action, perceived severity, perceived barriers, modifying variables, perceived benefit and its application on the study.

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CHAPTER THREE

METHODOLOGY

3.0 Introduction

The purpose of this study was to find out health care seeking behaviour among the aged in Niger State. Research design, population and sample of study, sampling techniques, instruments for data collection, procedure for data collection and methods of data analysis, are component of this study.

3.1 Research Design

For the purpose of this research, ex –post facto research design was used for this study to assess the health seeking behaviour among the aged in Niger State. ex –post facto is a research design in which the investigation starts after the fact has occurred without interference from the researcher (Sambo 2008). Therefore ex- post factor research design was found suitable for the study because it is not possible for the researcher to directly manipulate the independent variables.

3.2 Population of the Study

The study population comprises of the aged in the three senatorial district of Niger State. There are a total number of one hundred and sixty one thousand one hundred and fifty one (161,151) aged male and female people and a total of twenty- five (25) local government areas in Niger State,(Niger State Bureau of Statistics,2012).

Table 3.1 Population Distribution of Niger State by Five Year age Groups and Sex

AGE RANGE	MALE	FEMALE	TOTAL
60- 64	31,389	22,938	54,327
65-69	13,729	10,196	23,925
70-74	18,664	11,564	30,228
75-79	7,707	5,088	12,795
80-84	11,778	7,994	19,772
85- ABOVE	12,766	7,702	20,468
TOTAL	**96,033**	**65,482**	**161,515**

Source: National Population Commission- 2006 Population Census Result

3.3 Sample and Sampling Techniques

The three (3) existing senatorial district in Niger State were used for the study, sample for the study is drawn from the population using multi stage sampling technique. To determine the sample size for the study, stratified sampling is used to divide Niger State into three (3) senatorial district, namely Niger South , Niger East and Niger West, the reason been that stratified sample is a way of getting an average which represent the population of the study, according to Andy (2013), if the population is 161,151 then the required sample size for the study is three hundred and ninety- nine (399) at 5% margin of error and 95% confidence of interval . simple random sampling is used to draw Two local government area each from the stratum, where each of the local government area from each senatorial district is assigned numbers and written on a pieces of paper which is folded and thoroughly mixed in a small container, research assistant picked one piece of paper , the name was check and recorded as a sample, the reason being that random sampling ensures a good representation of each population and this implies that no

element of the population is omitted deliberately except by chance, this process is applied to all senatorial district belonging to the stratum.

Table 3.2 Respondents Table Based on Sample Size

Senatorial district	Sampled LGAs in Niger State	Sampled MALE POPULATION	Sampled FEMALE POPULATION	TOTAL
Niger south	Bida and katcha	78	55	133
Niger east	Chanchaga and bosso	65	70	135
Niger west	Wushishi and kontagora	63	68	131
Total		**206**	**193**	**399**

A total of six (6) local governments were randomly selected, two local government each representing a senatorial district as a sample, proportional sampling was used to draw the 399 respondents.

$$\text{Sample} = \frac{\text{total population of the study}}{1 + Ne^2}$$

Cluster sampling was employed to select the respondents across the six (6) selected local government, the reasons being that it is very feasible when dealing with large population. Each local government will be divided into wards, then two wards will be randomly selected from each local government and the respondents will be met at their homes and place of business.

3.4 Instrumentation

To achieve the purpose of the study, a structured questionnaire on health care seeking behaviour (HCSBQ) was developed by the researcher and used for the collection of data. The questionnaire consist of four (4) Sections, section A contains items on

demographic information, Section B consist of items on behaviour, and Section C consist of items on awareness, while Section D consist of items on practice. The instrument is a close ended questionnaire which the respondents are limited or confined to options given by the researcher. The questionnaire is constructed to elicit relevant information pertaining to the research question. The instrument has four (4) modified Likert scales which compel individual to emit their response to either agree or disagree. The responses was coded as, strongly agreed (4) agreed (3) disagreed (2) strongly disagreed (1).

3.5 Validation of the Instrument

In other to determine the validity of the instrument, a draft questionnaire was prepared by the researcher and submitted to the professional expert from physical and health education department for vetting**.** Their suggestion was adopted in the final draft of the questionnaire

3.6 Procedure For Data Collection

The researcher obtained clearance from the Department of Physical and Health Education, Ahmadu Bello University, Zaria. Respondents were met at home and place of business and briefed on the purpose of the study. Nature of the questionnaire was explained to them. After explaining, the researcher asked the respondents to fill the questionnaire.

3.7 Procedure for Data Analysis

Descriptive and inferential statistics is used in the analysis of data. The descriptive statistics involves the use of frequencies and percentage for the bio-data. The inferential statistics involves the answering of research questions and testing of the postulated null hypothesis.

The data collected were subjected to statistical analysis using the statistical package for social sciences (SPSS) version 21.0. 400 questionnaire were distributed and 399 (99%) were returned. Respondents were requested to rate their level of awareness on the scale of 1 to 4 (lowest to highest). The instrument was prefaced: Strongly agreed = 4, agree = 3, disagree =2 and strongly disagree = 1. Frequencies and percentages were generated from the respective responses of the respondents. 2.50 was rated as the midpoint between the two extremes of agree and disagree. Thus the criterion or acceptance mean of 2.50 was used in making decisions. If the relative mean of an item is equal to or greater than 2.50, it is considered that the respondents are in agreement with the suggested item while any mean less than 2.50 implies disagreement. The demographic variables are presented in frequencies and percentages while all other items are represented by their mean scores as expressed by the respondents. The corresponding standard deviations for each of the items are also shown in the respective tables. The standard deviation was calculated as a measure of awareness score variability from the mean score. Any low standard deviation indicates cluster of responses to the mean while high standard deviation reflected high variability of opinions from the mean

Analysis of Variance (ANOVA) and scheffe post-hoc were used to test the hypotheses at 0.05 level of significance and appropriate degrees of freedom while independent t- test to find out gender difference of the aged towards health care seeking behaviour. The results are presented and discussed according to the hypotheses stated in chapter one.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

The study aim at investigating the healthcare seeking behaviour among the aged in Niger State. Descriptive statistics was used to analyze each items of the questionnaire and mean score of 2.50 was considered as a baseline for making decision. The null hypothesis were tested at 0.05 alpha level of significance. In this chapter the result of analysis of data and discussion are presented.

4.1 Results

The socio demographic variables considered for this study include: Gender, Age, Marital Status, Respondents Status, and Educational Qualification of the Respondents. Table 4.1 below shows the socio demographic characteristics of the respondents.

Table 4.2.1 Demographic Characteristics of Respondents

Variables	Items	Frequency	Percent%
Gender	Male	185	46.4
	Female	214	53.6
	Total	399	100
Age	60-69	45	11.3
	70-74	117	44.4
	75-79	153	38.3
	80-above	24	6.0
	Total	399	100
Marital Status	Married	281	70.4
	Divorced/widowed	118	29.6
	Total	399	100
	None	3	0.8
	Primary	9	2.3
Qualification	Secondary	28	7
	Post Secondary	359	90
	Total	399	100

Table 4.2.1 above reveales that 185(46.4%) of the total respondents were male while 214(53.6%) were female. The ages of the respondents ranges from between 60-69 years to greater than or equal to 80 years. 45(11.3%) of the respondents were between the ages of 60-69 years, 117(44.4%) between 70-74 years, 153(38.3%) between 75-79 years and 24(6.0%) were above 80 years.

Out of the 399 respondents considered for this study, 281(70.4.5%) were married and 118(29.6%) divorced/widowed. With regard to the respondents level of education, table 4.0.1 reveales that the lowest qualification of the respondents is Primary School Certificate which accounts for 9(2.3%) of the total respondents, followed by Secondary Certificate with 28(7%) and Post-Secondary which accounts for 359(90%) of the total respondents. 3(0.8) of the respondents did not acquire Western Education. That concluded that majority of the aged have acquired Western Education.

Table 4.2.2 Health Care Seeking Behaviour of Respondents between the Ages of 60-69 Years

	Behaviour 60-69yrs	Mean	Standard Deviation
1.	I am comfortable visiting health centre when I am sick.	3.73	0.687
2.	I prefer visiting religious centre for treatment when i am sick.	3.27	0.939
3.	there is no enough Health services provided.	3.47	0.814
4.	The health dispensaries is not within my reach.	2.87	1.099
5.	I am necglated whenever i visit medical centre for treatment.	3.00	1.167
6.	I visit traditional healers for treatment when sick.	2.87	0.894
7.	I utilize more service of a caregiver than medical personnel.	2.67	0.953
8.	I am unable to utilize health care service because of its high cost	3.13	0.967
9.	I prefer home than medical centre whenever I need medical attention.	2.40	1.031
10.	I have insufficient transportation fee to visit medical centre.	3.20	0.990
Aggregate mean score		3.06	

The mean scores shown in table 4.2.2 above are based on the four points Likert Scale. The table shows that item number 1 had the highest mean score (3.73) which

indicates that the respondents are comfortable visiting health centres whenever they are sick.

Next to item 1 is item number 3, with a mean score of 3.47, which indicates that the respondents are aware that is no enough Health services provided. This is followed by item number 2, with a mean score of 3.27, which indicates the respondents prefer visiting religious centre for treatment when they are sick. For all other items, the mean scores were relatively greater than 2.50, which imply that the respondents agree with the suggested items except item 9 with a mean score of 2.40, this revealed that respondents do not prefer home than medical centre whenever they are in need of medical attention therefore the aggregate mean score of 3.06 indicates that significant majority of aged persons in Niger State seek healthcare services.

Table 4.2.3 Health Care Seeking Behaviour of Respondents between the Ages of 70-74yrs

	Behaviour 70-74 yrs	Mean	Standard Deviation
1.	I am comfortable visiting health centre when I am sick.	3.98	0.129
2.	I prefer visiting religious centre for treatment when i am sick.	3.20	0.707
3.	there is no enough Health services provided.	3.62	0.610
4.	The health dispensaries is not within my reach.	3.29	0.692
5.	I am neglected whenever I visit medical centre for treatment.	3.50	0.565
6.	I visit traditional healers for treatment when sick.	3.21	0.608
7.	I utilize more service of a caregiver than medical personnel.	3.41	0.726
8.	I am unable to utilize health care service because of its high cost	3.20	0.715
9.	I prefer home than medical centre whenever I need medical attention.	3.34	0.639
10.	I have insufficient transportation fee to visit medical centre.	3.13	0.730
Aggregate mean score		3.39	

Table 4.2.3 above show the descriptive statistics of the respondents' opinion as they seek healthcare services, from the table, the mean values of all the items exceed 2.50 therefore, it is significant that the respondents agree to all the items. The aggregate mean score of 3.39 indicates that significant majority of aged persons in Niger State seek healthcare services.

Table 4.2.4 Health Care Seeking Behavior of Respondents between the Ages of 75-79yrs

	Behaviour 75-79 yrs	Mean	Standard Deviation
1.	I am comfortable visiting health centre when I am sick.	4.00	0.000
2.	I prefer visiting religious centre for treatment when i am sick.	3.37	0.560
3.	there is no enough Health services provided.	3.58	0.694
4.	The health dispensaries is not within my reach.	3.43	0.570
5.	I am neglected whenever I visit medical centre for treatment.	3.44	0.676
6.	I visit traditional healers for treatment when sick.	3.35	0.719
7.	I utilize more service of a caregiver than medical personnel.	3.36	0.665
8.	I am unable to utilize health care service because of its high cost	3.30	0.649
9.	I prefer home than medical centre whenever I need medical attention.	3.34	0.770
10.	I have insufficient transportation fee to visit medical centre.	3.33	0.752
Aggregate mean score		3.45	

Table 4.2.4 above shows the descriptive statistics of the respondent's opinion as they seek healthcare services. From the table, the mean values of all the items exceed 2.50, therefore, it is significant that the respondents agree to all the items. The aggregate mean score of 3.45 indicates that significant majority of aged persons in Niger State seek healthcare services.

Table 4.2.5: Practice of the Aged Persons towards Healthy Aging

	Practice 70-74 yrs	**Mean**	**Standard Deviation**
1	I eat proper diet to promote healthy aging.	3.72	0.804
2	I exercise regularly to promote healthy aging.	3.30	0.765
3	Adhering to recommended treatment delay the on set of aging.	3.51	0.649
4	Interacting with health provider is a way of promoting my optimal health.	3.32	0.733
5	Health information's modify my life style.	3.38	0.673
6	Vitamins are necessary for me because of my fragile body.	3.31	0.811
7	Physical activity is compulsory to enable me have healthy living.	3.32	0.700
8	I practice better and effective hygiene to promote my heath.	3.38	0.759
9	I Access and seek health information for better healthy practice.	3.28	0.738
10	I practice regular medical check up to enhance my health.	3.29	0.785
Aggregate mean score		3.38	

Table 4.2.5 above displays the descriptive statistics on the practice of the aged persons towards healthy aging from the table, the mean values of all the items exceed 2.50. Therefore, it is significant that the respondents agree to all the items. The aggregate mean score of 3.38 indicates that significant majority of aged persons in Niger State practice healthy aging.

4.3. Major Hypothesis

There is no significant difference among the aged persons in healthcare seeking behaviour in Niger Stare

4.3.1 Sub Hypothesis 1

There is no significant effect of aging on health care seeking behaviour among the aged groups in Niger State.

Table 4.3.1 a: ANOVA Result on Effect of Aging on Health Care Seeking Behaviour Among The Aged Groups in Niger State.

	Sum of Squares	Df	Mean Square	F	P-value
Between Groups	774.645	3	258.215	12.135	.000
Within Groups	8404.788	395	21.278		
Total	9179.434	398			

F (3398) = 12.135< p(0.00)

Table 4.3.1 above is a analysis of variance table to test the hypothesis on whether or not there is a significant effect of aging in heath care seeking behaviour among aged in Niger State. Since the p-value (0.00) in the table in less than 0.05, therefore, we reject the null hypothesis and conclude that there is a significant effect of aging in health care seeking behaviour among the aged groups in Niger State at 95% or higher confidence level (p <0.05)

Table 4.3.1. Scheffe Post Hoc Test Showing Multiple Comparisons on Effect of Aging on Health Care Seeking Behaviour Among The Aged Groups in Niger State

(I) AGE	(J) AGE	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
60-69	70-74	3.28701*	.77010	.000	1.1249	5.4491
	75-79	3.89673*	.78225	.000	1.7005	6.0930
	80-ABOVE	6.40000*	1.16594	.000	3.1265	9.6735
70-74	60-69	-3.28701*	.77010	.000	-5.4491	-1.1249
	75-79	.60973	.50920	.698	-.8199	2.0393
	80-ABOVE	3.11299*	1.00339	.023	.2959	5.9301
75-79	60-69	-3.89673*	.78225	.000	-6.0930	-1.7005
	70-74	-.60973	.50920	.698	-2.0393	.8199
	80-ABOVE	2.50327	1.01275	.108	-.3401	5.3466
80-ABOVE	60-69	-6.40000*	1.16594	.000	-9.6735	-3.1265
	70-74	-3.11299*	1.00339	.023	-5.9301	-.2959
	75-79	-2.50327	1.01275	.108	-5.3466	.3401

*. The mean difference is significant at the 0.05 level.

Table 4.3.1 above shows a multiple comparison test using sheffe's method to determine the effect of aging on health care seeking behaviour among the different age groups. Age group 80 and above recorded a significant difference with group 70 -74yrs and 60-69 years respectively ($p<0.05$). More so, there is a significant difference between age group 60 – 69 and 70 – 74 at 95% or higher confidence level ($p<0.05$).

Age group 60 -69 years recorded the highest mean 19.4 compared to others groups. This signifies the group commitment in seeking for healthcare services.

4.3.2 Sub Hypothesis 2

There are no significant differences in practice of the aged groups in health care seeking behaviour in Niger State.

Table 4.3.2 a: ANOVA Result on the Differences in Practice of the Aged Person on Health Care Seeking Behaviour in Niger State

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	219.783	3	73.261	2.116	.098
Within Groups	13675.636	395	34.622		
Total	13895.419	398			

$F(3398) = 2.116 > p(0.098)$

Table 4.3.2a above is to test the hypothesis that, there is no significant difference in practice of the aged groups in health care seeking behaviour in Niger State. Since the p-value(0.098) on the anova table is greater than 0.05 ($p>0.05$) therefore, we accept the null hypothesis. Thus, there is no significant difference in practice of the aged persons on health care seeking behaviour in Niger State at 95% level of significance ($p>0.05$).

4.3.3. Sub Hypothesis 3

There are no significant differences among gender in health care seeking behaviour among the aged groups in Niger State.

Table 4.3.3 a Group Statistics

	Sex	N	Mean	Std. Deviation	Std. Error Mean
Behaviour	Male	185	15.8757	4.64392	.34143
	Female	211	16.2986	4.93587	.33980

Table 4.3.3a shows a descriptive analysis result between the male and female respondents on their health seeking behaviour. From the table, female respondents recorded the highest mean (16.30) compared to the male respondents with mean 15.88. This means that, aged women seek more health care services compared to their male counterparts in Niger State.

Table 4.3.3b: Independent Sample Test on the Differences among Gender in Health Care Seeking Behaviour among the Aged Groups in Niger State

		t-test for Equality of Means			
		t	Df	Sig. (2-tailed)	Mean Difference
Behaviour	Equal variances assumed	-.874	394	.382	-.42290

Table 4.3.3b is a two sample t-test to test the hypothesis that; there is no significant difference among gender on health seeking behaviour among the aged in Niger State. Since the p-value on the t-test table is greater than 0.05 (p>0.05), we reject the null hypothesis and conclude that there is no significant difference among gender on health seeking behaviour among the aged groups in Niger State.

4.3.4 Sub-Hypothesis 4

The awareness of the aged on health problems affecting their health care seeking behaviour in Niger State is not significant.

Table 4.3.4a: ANOVA Result on the Awareness of the Aged on Health Problems Affecting Their Health Care Seeking Behavior in Niger State

	Sum of square	Df	Mean square	F	Sig
Between Groups	296.159	3	98.720	4.492	.004
Within groups	8681.365	395	21.978		
Total	8977.524	398			

$F(3,398) = 4.492 < p(0.04)$

The table 4.3.4a, above is to test the significant difference in the awareness of the aged on health problems affecting their health care seeking behaviour in Niger State. Since the p- value (0.04) on the above table is less than 0.05 ($p > 0.05$) therefore, we reject the null hypothesis. Thus there is a significant difference in the awareness of the aged on health problems affecting their health care seeking behaviour in Niger State.

Table 4.3.4b: Scheffe Post Hoc Test on the Awareness of the Aged on Health Problems Affecting Their Health Seeking Behaviour in Niger State

AGE	N	Subset for alpha= 0.05
70 – 74	177	15.9379
60 – 69	45	16.7333
80 – above	24	16.8333
75 – 79	153	17.8366
Sig		.231

Table 4.3.4b above contains the post hoc using scheffe method to determine the variation between each group. There is a significant difference between age group 70 – 74 and 75 – 79 at 95% confidence level ($p< 0.05$), other group p- value is greater than 0.05 therefore no significant difference was recoreded among other groups ($p> 0.05$), age group 75 – 79 recorded the highest mean (17.84) in terms of the awareness of health problems affecting their seeking behaviour while age group 70 – 74 recorded lowest.

4.3.5 Sub Hypothesis 5

There are no significant differences among the aged groups of different educational qualification on healthcare seeking behaviour in Niger State

Table 4.3.5a: Anova Result on Differences among the Aged Groups of Different Educational Qualification on Health Care Seeking Behaviour in Niger State

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	230.050	3	76.683	3.385	.018
Within Groups	8949.384	395	22.657		
Total	9179.434	398			

$F(3,398)= 3.39 < p(0.018)$

Table 4.3.5a shows the result of testing the hypothesis on whether there is a significant difference among the aged of different educational qualification on health seeking behaviour among the aged in Niger State.

Since the p-value (0.018) in the ANOVA table is less than 0.05, therefore, we reject the null hypothesis and conclude that there is significant difference among the aged of different educational qualification on health care seeking behaviour in Niger State.

Table 4.3.5 b: Scheffe post hoc test on differences among the aged groups of different educational qualification on health care seeking behaviour in Niger State

(I) Education	(J) Education	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Did not attend school	Primary	-2.66667	3.89602	.494	-10.3262	4.9929
	Secondary	.64286	3.55020	.856	-6.3368	7.6225
	Post secondary	2.88022	3.38812	.396	-3.7808	9.5412
Primary	Did not attend school	2.66667	3.89602	.494	-4.9929	10.3262
	Secondary	3.30952	2.23930	.140	-1.0929	7.7120
	Post secondary	5.54689*	1.97227	.005	1.6694	9.4244
Secondary	Did not attend school	-.64286	3.55020	.856	-7.6225	6.3368
	Primary	-3.30952	2.23930	.140	-7.7120	1.0929
	Post secondary	2.23737	1.14668	.052	-.0170	4.4917
Post secondary	Did not attend school	-2.88022	3.38812	.396	-9.5412	3.7808
	Primary	-5.54689*	1.97227	.005	-9.4244	-1.6694
	Secondary	-2.23737	1.14668	.052	-4.4917	.0170

*. The Mean Difference is Significant at the 0.05 Level

Table 4.3.5b above contains the post hoc using scheffe method to determine the variation between each group. There is a significant difference between Post-secondary and Primary at 95% confidence level ($p < 0.05$), other groups p-values are greater than 0.05. Therefore, no significant difference was recorded among other groups ($p > 0.05$).

4.4 General Discussion

The findings of this study revealed that age significantly determines preventive health care seeking behaviour among the aged groups in Niger State. Odama (2014), conduct a study on health care seeking behaviour and found that majority of the elderly persons (62.7%) had age associated illnesses such as blood pressure, cardiac problems,

diabetes, joint pains, kidney infections, cancer and tuberculosis that take a long time to heal. Precisely 73.7% of the elderly patronized the hospital / health centre whenever they fell sick. More elderly males than their female counterparts were found to have patronized traditional healers, resorted to self-medication using local herbs or visited chemist shop whenever they were sick. The researcher recommends that the elderly people should be provided free , accessible and comprehensive health care in hospitals and health centres because they would utilize the health services when available, accessible and affordable.

The findings of this study reveals that women are more frequent users of health services than men. Ahmed et al (2004), reports that paraprofessionals such as a village doctor, a medical assistant or a community health worker and poverty status emerged as a major determinant of health seeking behaviour, the researcher concludes that they found socioeconomic status such as low income as the single most pervasive determinant of health care seeking behaviour among the study population.

Mackison (2003) in his study reveals that the reasons for the difference in health care practice could be the greater prevalence of illness among female, preference for women health care and availability of increased number of caregivers probably because women played more active role than men in the care giving process.

Menendez (2005), reports that health needs of the aged in terms of health care services shows poorly organized and inadequate home care, as part of primary health care service. This is an indication that care of the elderly has not been fully integrated into primary health care. This calls for concern and should be addressed by both policy makers and programme implementers. This study found that socio-economic status was the single most important determinant of health-seeking behaviour among the elderly. This is similar to findings from a previous study. Poverty status emerged as

the major determinant of health seeking behaviour. As a result of this, most elderly relied on home remedies from the family since they could not afford orthodox health care service simply because of high cost. Poverty, an important determinant of health care seeking behaviour, has similarly been reported in a previous study. Okoye, (2011) reports that the health seeking behaviour of the aged is determined by their attitude and that the elderly sometimes focuses exclusively on him or herself and try to use power, pressure, influence or control in ways destructive to their relationship with their caregivers. To some extent, the elderly person's behaviour can be self-centred and not noticing other people's feelings and not realizing when they are upset or when something you do upsets them. Occasionally, the elderly develop abusive behaviour.

Ali (2014) reveals that to enable health care practice for the older age, it is paramount that quality should be emphasized, quality in health care is a product of cooperation between patient and health care provider in a supportive environment, health care quality is the only means through which people will appreciate , accept, and practice optimal healthful living, according to Ali (2014) health care quality can be improved by supportive visionary leadership, proper planning , education and training of social workers and medical personnel, availability of resource, collaboration and cooperation among providers.

The preponderance of family care with home remedies (self-treatment) as the most common treatment chosen by the elderly when sick is a reflection of poverty and lack of social security and health insurance for the Nigerian elderly citizens. It could also be due to traditional belief in the study area that illnesses among the elderly are better treated with home remedies. Although self-treatment is an alternative and supplement to formal health care, it is equally very important that health care decisions taken by sick individuals or their givers are both safe and appropriate most especially self-treatment in

the case of the elderly people. Therefore, in order to make self-treatment safe and appropriate, some measures are needed to empower patients to make informed decisions.

This study also reveals that apart from self-treatment, cheap care provided by the health care workers (paramedics) and drug store sellers are other important sources of seeking health care by the elderly. Geriatric knowledge and skills are not included in the syllabus (course contents) of paramedics or does drug store seller know what medicine is contraindicated in old age. In view of this, these providers should be informed about health issues facing elderly people through formal and in-formal training. Basic training in use of essential drug list should be made available to all health care providers who are of greatest importance to the poor. Similarly managerial and regulatory measures should be introduced to control the use of potential drugs. Education of the elderly and their caregivers play an important role as observed in this study, in reducing the use of potentially dangerous drugs by enhancing an individual's capacity to assess services offered, to judge a provider's competence and to evaluate whether costs are justified and reasonable. The impact of education found in this study reflects the association between health and education and therefore underscores the need to promote literacy so that capacity to act appropriately in health care environment is increased.

Practice and Utilization of health care services by the elderly was low compared to their needs, especially with regards to home visits by physicians, nurses or social workers. Poverty is the most singe leading determinant of health seeking behaviour among the elderly. This could be reduced through offering of free health care services or subsidy for geriatric health care. Care of the elderly needs to be among priorities in annual health planning and policy formulation.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Summary

The purpose of the study was to assess the healthcare seeking behaviour among the aged groups in Niger State and to achieve the purpose of the study, five research questions were raised; one major hypothesis and five sub-hypothesis were formulated. They were aimed at identifying the influence of aging, gender and level of education, behaviour, awareness, practice and utilization of healthcare services in health seeking behaviour among the aged in Niger State. Niger State was selected as a case study and samples were drawn from the three senatorial zones in the State, three hundred and ninety nine respondents were sampled through purposive sampling technique. A structured questionnaire was used for the purpose of data collection. The statistical technique used in analyzing the data collected for the study were descriptive statistics of frequency counts, percentages, means and standard deviation, and inferential statistics of ANOVA, scheffe post hoc test and independent t-test. Major findings of the study revealed that:

1. aging significantly influence healthcare seeking behaviour among the aged in Niger State;
2. gender does not have significant influence on healthcare seeking behaviour among the aged in Niger State. Women recorded higher mean than male interms of seeking healthcare service;
3. level of education significantly determines preventive healthcare behaviour among the aged in Niger State;

4. Practice significantly determines preventive healthcare seeking behaviour among the aged in Niger State; and
5. awareness significantly determines preventive healthcare seeking behaviour among the aged in Niger State.

5.1. Conclusions

The following conclusions were drawn on the basis of the findings of the study:

1. age is significant in preventive healthcare seeking behaviour among the aged in Niger State;
2. level of education has a major influence on preventive healthcare seeking behaviour among the aged in Niger State;
3. practice determines preventive healthcare seeking behaviour among the aged in Niger State; and
4. awareness of health care services is significant to healthcare seeking behaviour among the aged in Niger State.

5.2. Recommendations

On the basis of the conclusion drawn from this study, the following recommendations were made;

1. Cost alleviation for the old seeking healthcare services should be put in place by the government in other to encourage them to patronize healthcare services
2. As revealed in the study, good health knowledge has positive impact on healthcare seeking and use. Thus improving awareness can have a large impact on improving healthcare seeking behaviour among the aged.

3. Increase availability of key services by health administrators are crucial approach to improve health care seeking behaviour among the old.
4. Establishment of public health centers in the core rural areas by the government would increase the proximity and accessibility of rural aged persons to public health facilities.
5. Periodic orientation should be conducted by health administration for health care personnel on rudimentary principles of human relations to make better friendly services.

5.3 Suggestion for Further Studies

Further study should be carried out on awareness, availability and utilization of healthcare services among the aged. Therefore, considering the fact the aged require knowledge about their health.

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APPENDIX

Dear Respondent,

I am a Masters student in The Department of Physical and Health Education Ahmadu Bello University, Zaria, carrying out a research on 'Health care seeking behaviour among the aged in Niger State' All information given will be completely used for academic purpose and will be confidentially treated.

Instructions; Please tick (√) the option that best represents your opinion

SA= Strongly Agreed, A= Agreed, U= Undecided D=Disagreed, SD= Strongly Disagreed.

SECTION A; Demographic Information of the Respondents

1. Sex

   Male ( )

   Female ( )

2. Age

   60-69 ( )

   70-74 years ( )

   75-79 years ( )

   80years and above ( )

3. Marital status

   Married ( )

   Single ( )

   Divorced ( )

4. Education.

Did not attend school ( )

Primary ( )

Secondary ( )

post secondary ( )

SECTION B: Health Care Seeking Behaviour Scale

	Behaviour	**SA**	**A**	**D**	**SD**
1.	I am comfortable visiting health centre when I am sick.				
2.	I prefer visiting religious centre for treatment when I am sick.				
3.	There is no enough Health services provided.				
4.	The health dispensaries is not within my reach.				
5.	I am neglected whenever I visit medical centre for treatment.				
6.	I visit traditional healers for treatment when sick.				
7.	I utilize more service of a caregiver than medical personnel.				
8.	I am unable to utilize health care service because of its high cost.				
9.	I prefer home than medical centre whenever I need medical attention.				
10.	I have insufficient transportation fee to visit medical centre.				

SECTION C: AWARENESS on Common Health Problems Affecting Aging

	Awareness	**SA**	**A**	**SD**	**D**
1	I am aware of some common health problems affecting my health.				
2	I am aware that aging can lead to occurance of some illness.				
3	I am aware that aging is associated with illness.				
4	I am aware that aging can lead to death due to infectious disease.				
5	I am aware that Dementia, diabetes and hypertension are the common illness of the aged.				
6	I am aware that the body system becomes dysfunctional due to age related illness.				
7	I am aware that aging is an illness and disease related stage in life.				
8	I am not aware that disease is closely related to aging.				
9	I am aware that common health related problems of the aged can be managed.				
10	I am aware that age related health problems cannot be avoided.				

SECTION D: Practice of the Aged Persons towards Healthy Aging

	Practice	**SA**	**A**	**SD**	**D**
1	I eat proper diet to promote healthy aging.				
2	I exercise regularly to promote healthy aging.				
3	Adhering to recommended treatment delay the onset of aging.				
4	Interacting with health provider is a way of promoting my optimal health.				
5	Health information's modify my life style.				
6	Vitamins are necessary for me because of my fragile body.				
7	Physical activity is compulsory to enable me have healthy living.				
8	I practice better and effective hygiene to promote my heath.				
9	I Access and seek health information for better healthy practice.				
10	I practice regular medical check up to enhance my health.				