

AGEING AND HEALTH: A COMPARATIVE STUDY OF RURAL AND URBAN AGED HEALTH STATUS IN BAYELSA STATE, NIGERIA

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Abstract

This study investigates Ageing and Health: A Comparative Study of Rural and Urban Aged Health Status in Bayelsa State, Nigeria. The study after reviewing literatures relating to the study made use of the life course theory as the theoretical base to back up the study. 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. Data collected from the field were analysed using tables, mean, standard deviation and the Z-test for the testing of hypotheses. Findings from the study revealed 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 like social support for the elderly, creating special wards for the elderly, etc. were made in the study by the researcher.

Keywords: Ageing, Health, Rural Aged, Urban Aged, Life course theory

Introduction

Recently, the issue of health in the elderly has drawn a great deal of attention worldwide, and there are more and more people devoting themselves to the field of the elderly. Since the elderly have a better and healthier life by participating in leisure activities. The Elderly comprise a considerable portion of the Nigeria population; based upon 2001 data, they represent 7.4% of the total population, and 57.2% of those aged 65 and above (Nigeria Bureau of Statistics 2006). Indeed, it is projected that the percentage of people between 65 years of age or older will increase to 11.7% of the Nigerian population by the year 2026 (Nigeria Bureau of Statistics

2006). Moreover, many elderly are poor; 21.5% of people 65 years of age or older were considered low income in 2000, as measured by the Nigeria Bureau of Statistics low-income cut-offs (NBS 2006).

In fact, older people are more likely than younger people to be poor at each stage of their lives, as well as being more likely to be ensnared in a lifetime of poverty (Lochhead & Scott, 2000). This general trend of poverty among the elderly is worrisome, given that income is a major determinant of health (Bolig, Borkowski & Brandenberger, 1999). Thus, given that the Aged 65 and older will make up an ever greater portion of the Nigerian population in the future, their health and well-being will also be of increasing importance. Additionally, more 75 of seniors in Nigeria are living in rural areas (Nigeria Bureau of Statistics 2006), and as will be shown, these seniors have unique challenges and experiences due to their rural residency.

Research establishes that rural residency can have both a positive and negative effect on health (Gerritsen, Wolffensperger & Van Den Heuvel, 1990; Mitura & Bollman, 2003). Notably, individuals with low income are more prevalent in rural areas, and are associated with poorer health status. Research also suggests that rural residents receive more community support (indicating a higher level of “social capital”), which may suffer the effects of low-income on health status (McCulloch, 1998; Pearson, Scott & Roberto, 1987). These findings on the impact of rural residence on elderly health in relation to these seemingly contradictory patterns therefore need to be explored in more detail. An enormous proportion of the world’s elderly live in rural areas and show wide variations in health status. Many, particularly those in the developing countries, are vulnerable to greater socioeconomic and health marginalization mainly due to inadequate provision of services and economic deprivation. As with the urban elderly, locomotor, visual and hearing disabilities, as well as life-threatening conditions of coronary heart disease, diabetes and hypertension are common among rural elders also. Infections continue to take a heavy toll in the lives of the elderly in many parts of the world.

The Differences between the Health Statuses of Rural-Urban Elderly

From a study by Wanless (2005), it was discovered that; the elderly who reside in rural areas were more likely to have any chronic condition, hypertension, diabetes and heart disease than those in urban areas. However, there was no rural advantage in regards to self-rated health. The research also showed that for the elderly, those who reside in rural areas were worse off on a number of health measures than their urban counterparts, particularly in terms of circulatory diseases. These differences were observed even after controlling for socio-demographic characteristics, socio-economic status, social capital, and lifestyle. Clearly, this indicates a larger distinction

between the health of rural and urban elderly than. These health differentials indicate that not enough has been done to bridge the gap between rural and urban areas. However, the cause of such differences remains unclear. Rural elderly were more likely to have any chronic condition, hypertension, diabetes and heart disease. This may be attributed to inadequate health care in rural regions, particularly in terms of chronic disease management, as well as a lack of education and resources regarding the causes and prevention of such conditions, Wanless (2005).

Essentially, while rural elderly were not advantaged in terms of subjective health, as was predicted, they were also not at a disadvantage, in spite of having worse objective health. In other words, it was expected that among groups who are more likely to experience various chronic conditions, they would also be more likely to report their health as fair or poor, as a reflection of these conditions. It had been predicted that the rural elderly would be advantaged on the subjective health measure, but disadvantaged in terms of objective health, and that this would be attributed to a higher level of social capital. In actuality, very modest support was found for the mediating effect of social support. Thus, support was not found for the conundrum proposed, and as such, this adds greatly to the inconsistent findings in the literature reviewed in relation to rural-urban subjective health differentials. Indeed, the strongest findings were those related to the different predictors of health for rural and urban groups, Wanless (2005).

Consequently, another major finding was that: the health of rural elderly was predicted by different covariates than the health of urban residents. The comparative analysis conducted revealed that the model used was far more effective at predicting the health of urban elderly, while it was much less likely to do so for rural elderly. In particular, the socio-economic status (household income, education, food insecurity) and social capital (social and community support) variables were associated with the health status of urban elderly much more often than for their rural counterparts. It is surprising that the social economic status and social capital are not as important for the health of rural elderly, as it was expected that these factors would be better predictors for rural residents, because their social economic status is usually lower, while social capital is higher, compared to urban areas. This unanticipated finding shows that the health of rural and urban elderly is much more complicated than previously thought, and this has implications for the applicability of the social determinants of health model identified by Raphael (2004).

In Overall, social determinants of health appear to predict the health of urban elderly to a considerably better degree than for rural aged. It is possible that social determinants of health vary depending on rural-urban residence, and therefore, the current model of determinants is not necessarily

pertinent to rural persons. Perhaps we need to examine the social determinants model more closely to see what it is missing with regard to rural populations of older women, as these determinants evidently do not explain away the rural-urban health differences, as it was proposed they would. Clearly there are other factors which are influencing the health of the elderly in rural regions, than what was available to be examined in this study. This may be attributed to such factors as health care utilization and access to resources which were not included in the model. For instance, there is a tendency for rural seniors to value their independence highly, and thus attempt to limit dependence on formal services available (Shenk, 1998). As such, driving status may have a large impact on rural women's health, given the lack of public transportation in rural areas and the distances which are necessary for one to cover on a regular basis. It is expected that this measure of independence and access to resources and services would be much more important to rural residents, than those in urban areas. Yet, it is also likely that rural culture have impacts on the health of the elderly in a manner unmeasured.

It was expected that rural culture would be assumed within measures of socio-economic status, social capital and lifestyle; however, it seems that there are other aspects at work not measured. It is important to note that the lifestyle variables in the model (physical activity and smoking status) are fairly basic and the inclusion of others (i.e. diet measures, etc.) may have been beneficial. In addition, other factors previously discussed but which were unable to be included in the analysis (i.e. other social capital variables, like religiosity and voluntarism; health care utilization) may have added to the findings, however, it is possible that there is a rural mind-set and approach which was not captured with the variables available in the CCHS. For instance, there may be differences in rural and urban populations in terms of the diagnosing and self-reporting of health status. It may be such that rural Aged is less aware of whether or not they have had a professional diagnosis of health conditions and as such may misreport these conditions.

Also, they may lack general health knowledge, in addition to not having an in-depth awareness of their personal health. Rural elderly may also be less likely to acknowledge any health problems, particularly in terms of subjective health status, due to a self-identity as "resilient". These issues could result in a degree of measurement error when depending on the self-report of health status. Also, in addition to factors like religiosity and voluntarism, there may also be a rural-urban difference in terms of a "value system" or community morals. Turning to specific differentials, the third key finding from the research was that: socio-economic status was associated with poorer health status, particularly among urban-dwelling older women. As expected, socio-economic status had a great impact on the health of the

elderly, particularly urban-dwelling respondents. While the fact that income was revealed to be a major social determinant of health is not surprising, it reiterates the supposition that more needs to be done to bridge the income gap. This is particularly true for the elderly, who are more likely to be in dire financial circumstances, due to the life course causes of poverty.

However, while it has been shown that rural areas has lower incomes than urban does, socio-economic status did not predict the health status of rural elderly to the degree that it did for their urban counterparts. Though socio-economic status, as measured, may not have been directly associated with their health, it remains possible that the low-income levels of rural elderly influence other aspects of one's health status, such as psychological well-being. There is clearly a need to further elucidate the economic and social differences in rural and urban areas, particularly among elderly.

Theoretical Framework

It is a truism to state that a research work in the social sciences (especially in sociology and political science), would remain inconclusive without the provision of a space for a theoretical framework for analyzing the subject matter of discussion. However, for the theoretical requirement of this work, we have adopted the **Life course theory**. **The life course perspective** is a useful framework for examining health-related issues of the elderly. It is a multidisciplinary approach that is well-suited to the study of individual lives within structural contexts and amidst social and economic change (Elder, 1985; Hagestad, 1990; Hareven, 1994). Of particular relevance to this study is its focus on the interaction of socio-demographic, socio-structural, cultural and geographic factors. As such, this theory allows consideration of a variety of factors which may impact an older adult's health, such as their degree of family and community integration, kin support, and income level.

A fundamental tenet of this framework that we build upon in this work is the notion of heterogeneity in access to resources and how this impacts health in later life. Resources may be material (e.g. financial and household resources) or non-material (e.g. social capital). Access to resources can be seen as rooted in one's place of residence, available social support and financial capital. Specifically, both low-income levels and rural residence can affect one's access to resources and this is likely to impact health status. It should also be noted that applying life course theory to health outcomes, as this study proposes, is a novel and practical approach. "Put simply, individuals (and their ill-health) cannot be understood solely by looking inside their bodies and brains; one must also look inside their communities, their networks, their workplaces, their families and even the trajectories of their life" (Lomas, 1998). Indeed, an important distinction

that is made in the literature is between biomedical and behavioural health determinants (i.e. cholesterol levels, physical activity, smoking status, etc.) and “social determinants of health.” The latter refers to the “economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole” (Raphael, 2004). While definitions differ across studies, Canadian researchers recently identified eleven social determinants of health which are as follows: Aboriginal status; early life; education; employment and working conditions; food insecurity; health care services; housing; income and its distribution; social safety net; social exclusion; and unemployment/employment security (Raphael 2004). In addition, gender interacts with all of these social determinants to influence health status, which have been found to have a greater influence on the health of Canadians than biomedical and behavioural factors.

The life course perspective is particularly useful when considering these determinants of health, as noted by Raphael (2004): Adopting a life course perspective directs attention to how social determinants of health operate at every level of development to both immediately influence health as well as providing the basis for health or illness during the following stages of the life course. A related concept that is frequently integrated within the life course literature is that of “social capital”. This term refers to the quality of and support from familial relationships, and can also be found in the community setting (Bowen, Richman & Bowen, 2000). This concept is similar to social support and can affect one’s health and well-being. Coleman (1988), a pioneer of social capital conceptualization, also described it as being productive, in that social capital makes certain events possible which would not have occurred in its' absence. Two related concepts are financial and human capital. Financial capital refers to a family’s available economic or physical resources, whereas human capital is the knowledge and/or skills of the parents and the capabilities of the children (Bowen, et al.). In fact, Bowen, et al. asserts that, “social capital is perhaps the most important of the three types, for without it, financial capital may assume little meaning and human capital may not be translated into positive outcomes for family members”. Social capital, therefore, plays an important role in the proposed research, particularly regarding the impact on elderly women’s health. For instance, a study of health districts in Saskatchewan found that communities with higher social capital (measured by associationalism and civic participation) had a lower mortality rate, fewer encounters with mental health and alcohol/drug services, and had more people 65 years of age or older (Veenstra, 2002). Lomas (1998) observed in a study examining a number of possible responses to fatal heart disease that “interventions to increase social support and/or social cohesion in a community are at least as

worthy of explanation as improved access or routine medical care” with each intervention having at least some impact on the prevention of deaths.

However, it is recognized that social capital involves a number of dimensions, such as civic engagement, civic identity, community networks and norms (Robert, 2002). Thus, it is recognized that due to its abstract nature, it is difficult to consistently define across studies (Liu & Besser, 2003). Additionally, while much of the literature emphasizes the positive aspects and consequences of social capital, a number of negative features may also be associated with this concept, such as the exclusion of others, excessive demands and claims made on individuals, and the restriction of freedom and choice (Portes, 1998). While this research focuses on the positive characteristics of social capital, it is essential to note that these negative aspects should also be taken into consideration. The life course perspective is also relevant to the issue of late life poverty; This framework allows for the consideration of women’s individual choices (e.g., regarding marriage and labour force participation), the structural contexts which these decisions are made within (e.g., the acceptance of women in the labour force, the gender gap in pay), and the various transitions many women experience in early, mid and late life (e.g., widowhood) (Vartanian & McNarmara, 2002). As will be briefly outlined, there are various causes, both individual and structural, for women’s late life poverty and the life course perspective provides a framework in which to consider these, as well as the impact low-income levels may have on one’s health and well-being.

Finally, Crystal and Shea (1990) discuss the concept of cumulative advantage/ disadvantage, which also has relevance for this study. This notion suggests that inequalities (e.g., gender, ethnicity, and rural residency) may be accumulated over the life course, resulting in late life poverty. Poverty among seniors has been attributed to both the current conditions faced, such as life transitions like retirement and widowhood, and the cumulative effects of the lifelong experiences of these seniors, including the possibility of experiencing lasting disadvantages (Glasgow & Brown, 1998). Glasgow and Brown also discuss the possible disadvantages of rural residency, such as economic constraints, limited opportunities and constraints within the social structure. However, it is also anticipated that there are advantages to rural residency, in terms of social capital and cohesion. Thus, not only is the life course perspective useful for the examination of the impact of low-income on one’s health, it is also very valuable in terms of explaining the cumulative effect that rural or urban residency may have on health.

Methodology

The survey design was adopted which focus is to describe ageing and health: A comparative study of the health differences between rural and urban communities using Bayelsa State as a case study. Thus, since the researcher cannot adequately cover the entire Rural and Urban areas in Bayelsa State, a sampled size of 216 respondents representing about 0.28% of the population was selected and findings generalized to the entire population of study. The simple random sampling method was used to select 36 persons each from selected Five (5) communities and the State Capital; Yenagoa making up a total of 216 persons.

This research work employed two sampling methods. First, the stratified sampling technique was used to stratify the respondents into two important groups; The Rural Aged and the Urban Aged. Then the simple random sampling method was used to select six (6) communities in five Local Government Areas namely: Otusega, Otuan, Akassa, Peretoru and Okoloba and Yenagoa. Yenagoa City was the only urban centre selected as it serves as the major city in all of Bayelsa State, making all the areas six of which the rural areas got 23 questionnaires each, while the urban area got 101.

This research work collected data by a combination of both primary and secondary sources. First the secondary sources of data collection which involves information from journals, magazines, newspapers, textbooks and internet. Secondly, the primary source was used to elicit information from the respondents using a detailed structured and unstructured questionnaire alike. The questionnaires were designed by the researcher and given to Rural and Urban Elderly to fill. The data was collected with helped of some local youths who helped in the interpretation of the questionnaire to those who could not understand or speak English. The questionnaire was divided into four sections. Section A contained the letter of introduction to the respondents seeking to explain the aim of the research and who the researcher is. Section B contained questions on the Socio-Demographic characteristics of the respondents; section C contained questions for the Rural Aged and their health status, while section D was designed for Urban Aged on the health question bordering on their health Status.

The researcher used analytical tools such as tables, mean, standard deviation and Z-test for the analysis of the data collected. The simple Percentage was used to analyse the socio-demographic characteristics of the respondents while the mean and the standard deviation were used to analyse the 5 point Likert scale of Strongly Agree (SA-5points) Agree(A-4points) Disagree (D-3points), Strongly Disagree (SD-2points), and Undecided (UN-1point), while the chi square was used for Hypothesis testing in the study.

The mean cut off for accepting or rejecting any item was 2.50 based on the 5point Likert scale. The decision rule was that any item with mean score from 2.50 and above will be accepted while items with mean score below 2.50 will be rejected. The Z-test was used to test the relationship between the mean response of both the elderly in the rural areas and the urban elderly about their health status.

The instrument used was validated by a team of professional Social science researchers which include; Some Lecturers and Graduate Students who were experts in the topic of discuss. They assisted in the design of the questionnaires by making relevant corrections of the previous questionnaire designed by the researcher. The instrument used for the validation, was also critically examined by experts in measurement and evaluation and their corrections and observations were incorporated into the final draft.

The reliability of the instrument was determined using the test/retest method. Copies of the instrument were administered to ten neutral respondents. The same instrument was administered to another set of ten respondents after two weeks. The scores from the two groups were collected for the calculation of the correlation coefficient of the scores of the two groups using the Pearson product moment correlation (PPMC) formula. A correlation coefficient of 0.64 was obtained. There is a strong positive correlation between the two pairs of scores of the respondents because the calculation gave 0.64 as the correlation co-efficient of 0.64 from the calculation; the instrument used for the study is quite reliable.

Discussions and Findings

The socio demographic characteristics in table 1 revealed the following about our respondents, 106 (49.1%) of our respondents were made up of male, 110 (50.9%) were female. Still, majority of our respondents 138(63.9%) were within the age bracket of 66-70, 47(21.8%) were between 60-65 years while 31(14.4%) of them were 71 and above years. More so, 155(71.8%) of our respondents are those who are married, 13(6.0%) of them are divorced and 48(22.2%) of them are those who have lost their spouses. Furthermore, 63(29.2%). of our respondents have no formal education, 36(16.7%) have primary education, 73(33.8%) has secondary education while 44(20.4%) of our respondents have tertiary and above qualifications.

In addition, 93(43.1%) of our respondents are mainly engaged in Agricultural Activities such as; farming, fishing, animal husbandry, hunting etc, 29(13.4%) of them are Civil Servants, 67(31.4%) are pensioners while 27(12.5%) of them have no occupation they are engaged in. Again, 52(24.1%) of our respondents have an income of N5, 000 per month, 42(19.4%) of them earn between N5, 000-N10, 000 month, 43(19.9%) earn between N11, 000-N20,000 per month,31(14.4%) receive a monthly income

of about N21,000-49,000, while 48(22.2%) of them earn between N50,000 & above per month.

Additionally, 93(43.1) of our respondent are having between 5-10 children, 101(46.8%) are having between 11-15 children while 22(10.2) of our respondents are having 16 and above children. Finally 211(97.7%) of our respondents claimed to be Christians, 5(2.3%) stated that they are traditional worshippers while there was no Muslim found among our respondents.

Table 1- Socio-Demographic Characteristics of Respondents

Items	Response		
		Frequency	Percentage
SEX	Male	106	49.1
	Female	110	50.9
	Total	216	100.0
AGE OF RESPONDENTS	60-65years	47	21.8
	66-70years	138	63.9
	71 and above	31	14.4
	Total	216	100.0
MARITAL STATUS	Single	-	-
	Married	155	71.8
	Divorced	13	6.0
	Widowed	48	22.2
	Total	216	100.0
EDUCATION	No education	63	29.2
	Primary education	36	16.7
	Secondary education	73	33.8
	Tertiary and above	44	20.4
	Total	216	100.0
OCCUPATION	Agricultural Activities	93	43
	Trading	-	-
	Civil Servants	29	13.4
	Pensioner	67	31.4
	No occupation	27	12.5
	Total	216	100.0
ESTIMATED INCOME PER MONTH	N5,000	62	24.1
	N5,000 -N10,000	42	19.4
	N11,000 -N20,000	43	19.9
	N21,000 -N49,000	31	14.4
	N50,000 & above	48	22.2
	Total	216	100.0
PLACE OF RESIDENCE	Rural	116	53.7
	Urban	100	46.3
	Total	216	100.0

NO OF CHILDREN	1-4	-	-
	5-10	93	43.1
	11-15	101	46.8
	16 & above	22	10.2
	Total	216	100.0
RELIGION	Christianity	211	97.7
	Islam	-	-
	ATR	5	2.3
	Total	216	100.0

Source: Field Research 2015

From table 2 below, the following deductions could be made; the respondents accepted that the rural aged fall sick more often compared to their urban counter part. This receives a mean score of 3.13 and a standard deviation of 1.77. More so, items 2 which have a mean score of 3.26 and a standard deviation of 1.81 also shows a high level of acceptance that lower level of income is associated with lower health status for the rural aged. Still, the response in item 3 which has a mean score of 3.45 and a standard deviation of 1.86 indicates that respondents accept the notion that lower levels of social and community support is associated with lower health status experiences by the rural elderly.

Furthermore, item 4 with a mean score of 3.39 respondents deviation of 1.84 shows respondents accepted the proposition that the health problems of the rural elderly is different from these of the urban Aged. Also, item 5 which received a mean score of 3.80 and a standard deviation of 1.84 shows a general levels acceptance of the notion that lower income, lower levels of community support, lack of health facilities, distance to health centres etc are associated with poor health status for the rural elderly. Finally, item 6 which attracted a mean response of 1.77 and a standard deviation of 1.33 indicated a wide rejection that the government has put in place modalities to bridge the gap between the poor rural elderly and their rich urban aged.

Table 3 showed the level of acceptance or rejected from the respondent in the urban areas. Item1 with a mean score of 3.05 and a standard deviation of 1.75 indicated that the urban aged in the rural areas does. Item 2 had a mean score of 3.58 and a standard deviation of 1.89 indicating respondents choice of response that higher income, which the urban aged pose is associated with a higher health status they poses. Also, item 3 with a mean score of 3.44 and a standard deviation of 1.85 showing that higher levels of social and community accorded to the urban elderly is associated with higher health status. In addition, item 4 which attracted a mean score of 3.64 and a standard deviation of 1.91 revealed that higher incomes, high levels of community support, availability of health facilities,

higher education, and other factors is associated with higher health status among the urban elderly. Again, item 5 got a mean score of 3.21 and a standard deviation of 1.79 revealing that respondents accepted that the health problems of the urban elderly is different from those of rural elderly. Finally, item 6 with a rejection mean of 1.80 and a standard deviation of 1.34 showed that respondents disagreed to the modalities to bridge the gap between the poor health of the rural and urban elderly.

Table 2- Analysis of the Data from the Rural Respondents.
Source: Field Research 2015

Item	X	SD	Decision
Rural Aged often fall sick more than urban elderly	3.13	1.77	Accept
Lower Level of income is associated with lower health that rural aged Experience	3.26	1.81	Accept
Lower levels of socials & community support is associated with lower health among rural elderly	3.45	1.86	Accept
The Health Problems of the rural elderly is different from those of urban elderly	3.39	1.84	Accept
Lower income, lower levels of community support, lack of health facilities, Distance to health centres etc are associated with poor health status for the rural elderly.	3.80	1.95	Accept
The Government has put in place modalities to bridge the gap between the poor rural elderly and their rich urban aged.	1.77	1.33	Reject

Table 3- Analysis of the Data from the Urban Respondents
Source: Field Research 2015

Item	X	SD	Decision
Urban Aged does not fall sick often like the rural aged	3.05	1.75	Accept
Higher level of income is associated with high health that the urban aged might experience	3.58	1.89	Accept
High levels of social & community support is associated with higher health among the elderly	3.44	1.85	Accept
Higher incomes, High levels of community support, Availability of health facilities, Higher education, and other factor is associated with Higher health status among the urban elderly	3.64	1.91	Accept
The health problems of the urban elderly are different from those of the rural elderly.	3.21	1.79	Accept
There are modalities put in place by the Government to b bridge the gap between the poor health of the rural and urban elderly.	1.80	1.34	Reject

Hypothesis Testing

Ho: There is no significant relationship between the mean response of the rural aged response about their health status and that of the urban elderly.

Table 4

Group	MEAN	SD	N	SE	Z-Cal	Z-crit
Rural elderly response about health status	3.39	1.84	106	0.187	0.96	0.3289
Urban elderly mean response of health status	3.21	1.79	100	-	-	-

Source: Field Research 2015.

From table 4, the Z-cal is 0.9 while the Z-crit is 0.3289 for a two tailed test at 0.05 level of significance which was determined from a table of areas under a normal curve.

Decision Rule: Since the Z-cal is greater than the Z-crit, the null Hypothesis is rejected. This means that there is a significant relationship between the mean responses of rural elderly and that of the urban elderly about their health status.

Conclusion and Recommendations

From the summary of findings gotten from the data analysed in our study above, the following conclusions have been deduced:

- i) The aged who live in the rural areas are more often going to suffer from health related problems than those aged who live in the urban cities with all the health facilities present.
- ii) Those poor elderly who live in the rural areas are more likely to experience lower health status than the aged who are wealthy and live in the urban centres since they can afford all health expenses.
- iii) Those elderly with lower levels of social and community support are more likely to have a lower health status than those who enjoy high level of social and community support from families and kin members.
- iv) The Elderly in rural societies have lower health status in general compare to those elderly in urban societies with all its basic facilities.
- v) The health problems experienced by the aged in the rural areas are different from those health challenges which the urban aged experience.
- vi) Factors such as; low income, lower levels of community support, lack of health facilities, distance of health centre's etc could be responsible to a great extent for the lower level of health status experience by the aged in rural societies, while the availability of the

above factors gives a higher level of health status to those elderly who live in the urban centres.

vii) Government effort to bridge the gap between the low level of health experienced by the rural elderly and higher level of health enjoyed by the urban aged has not be fruitful. Hence, the aged in rural societies still suffer from poor health problems.

Based on the aforementioned conclusion from study, it is expedient that recommendations be made to help ameliorate the health challenges experienced by the elderly, especially the rural aged with poor health status. Below are some recommendations made by the researcher to reduce the level of problem observed from the study, they are as follows;

- ❖ Firstly, special geriatric wards should be established especially in the rural areas where more elderly who are more likely to fall sick are residing. This will help bridge the gap of distance which makes most rural elderly not to patronize medical help.
- ❖ Secondly, there is a need for the government and philanthropic individuals to provide subsidized or concessional health care facilities as most of the aged especially in the rural areas are backward economically and cannot afford expensive medical bills.
- ❖ Furthermore, special wards for treating the aged in hospitals should be established just as we have children's ward in medical centres across the country. This will to a large extent help the elderly to be promptly attended to instead of them to be waiting in long queues to be attended to.
- ❖ Additionally, more viable non-governmental organizations that cater for the real health needs of the elderly especially those helpless elderly found in rural areas and destitute places should be encouraged by both government and well-meaning Nigerians both financially and morally so that they can carry out their duties more efficiently.
- ❖ Also, there is a need for insurance scheme to enable the elderly to meet their medical expenses. All, those working; both civil servants self-employed individuals should be encouraged to be part of this scheme so as to have their health need's catered for when they are old.
- ❖ Finally, social security benefits should be paid monthly to be Aged especially poor rural aged. This will help them meet their socio-economic and basic needs which will in turn boost their health status. Although the Bayelsa State government has started paying N10, 000 Naira to the aged in the state, there is need for the money to be increased as that can hardly solve the physical and medical needs of the aged.

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