

# Family Composition and the Utilization of Healthcare Facility among the Elderly in Ajah Community, Lagos State, Nigeria

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## **Abstract**

*The family structure of older Nigerians is projected to change dramatically as a result of increasing levels of single-person and couple-only households, very low fertility, non-marriage, childlessness, and divorce, and declining intergenerational co-residence. This study examined the structure of the family system on the utilization of healthcare services among older persons in Ajah community, Lagos State. It has been well established that the changing family structure influences the wellbeing of older people in the society. The study employed the Family Systems and Dependency paradigms as theoretical frameworks to analyse the subject matter. The study adopted purposive sampling method to select participants and respondents for qualitative data. Findings revealed that parent-children relationship and support of family members (especially children) are closely linked with appropriate usage of healthcare facilities by the elderly.*

**Key words:** family structure, healthcare, older people, utilization, well being

## **Introduction**

Population ageing is one of the greatest challenges in the 21st century as countries face increasing economic and social pressures from a growing elderly population in Nigeria. By 2025, it is estimated by the World Health Organization (WHO, 2003) that there will be a total of 1.2 billion people over the age of 60. This is projected that this will rise to two billion in 2050 which will have implications for the dependency ratio. Elderly population is increasing in all countries of the world as a result of several factors such as decline in fertility, improvement in public health, increase in life expectancy and changes in living arrangement among the family structures. The ageing of population has become a common phenomenon as a result of increasing longevity and declining fertility (Cowgill, 1986). The world's total population is growing at a rate of 1.7 percent per year. The population aged 60 years and above is increasing by 2.2 percent per year; and the number of persons aged 65 years and over, is rising by 2.8 percent annually (UN, 2015). It is expected that this demographic pattern will continue. Even though population of the elderly is increasing in all countries of the world, up till the early 80's, the

demographic transition was mostly viewed as a phenomenon of the developed countries (Sylvia, 2000; Troisi, 2004).

As observed in the literature, the majority (two-third) of those over 60 years of age live in the developing world and the proportion is increasing steadily and will reach nearly three-quarters by 2030 (UNFPA and CBGS, 1999). Troisi (2004) noted that already in 1985, 56.5 percent of the world's elderly lived in developing countries and this proportion is projected to reach 61.5 percent by the turn of the century and 71.9 percent by the year 2025.

With sub-Saharan African societies coming under various cultural influences and scourge of HIV/AIDS affecting the youths, the traditional institution that supported elderly care is highly threatened. The extended kinship support is gradually declining under the pressure of modernity (Togonu-Bickersteth, 1989). Economic woes and recession, coupled with governments' failure in the region, also compounded the problems of the elderly as they have been largely neglected in various issues that affect them. Evidence suggests that most African countries are inadequately prepared for the emerging challenges of the growing elderly population (United Nations, 1994).

It is often claimed that ageing is accompanied by multiple illnesses and physical ailments. Besides physical illnesses, the aged are more likely to be victims of poor mental health, which arises from senility, neurosis and extent of life satisfaction. Healthcare provided by the family attempts to satisfy the needs of older persons. But with changing social and economic configurations, older persons are most of the time left in the care of strangers i.e. people who are not properly trained to be caregivers, many of them uneducated, young and frustrated. Therefore, has family structure affected the healthcare provision and utilization for the elderly? It is against this backdrop that this study attempts to examine how family structure influences and sustains healthcare utilization of the elderly in Ajah community, Lagos State, Nigeria.

### **Statement of the Problem**

In traditional societies, family members imbibed their parents' cultural traits strictly and the care for the elderly was seen as very important. Similarly, parents procreated a large number of children then to assist them in their domestic chores and farming and socialized them into gender roles. However, with increasing urbanization and the resultant growing complexity of urban social space, there are emerging problems associated with the new mode of life of changing family structure, including old age negligence, because many people perceive old people as no more relevant and useful to the society. Of these, the physical (health) factors are the prime concern of this study. These include lack of quality food, drugs, affection, and cleanliness among others.

In addition, changing family structures will have an impact on the well-being of the older population now and in the future. Changes in family structures also influence the need for formal support systems of the elderly. There are several alternate forms of family and generational structure that are

shaped by changes in marital status, fertility, mortality and migration. Much of the research on aged people has focused on the traditional paths through the life course (e.g., marriage, bearing children and widowhood) and has largely ignored the alternate pathways and their consequences on living arrangements and well-being in later life. Declines in fertility, often quite rapid, now characterize most developing countries. Research on and micro simulation of kin availability suggests that tomorrow's elderly will have fewer children upon whom to rely on, though this may be offset by increased joint survival of spouses. In the Republic of Korea, as example has shown, although declining fertility results in an increase in the proportion of Korean women with no surviving son, increased male longevity means that the proportion of elderly widows will also decline. Consequent on the problems identified above, the study attempted to answer the following research questions:

1. What is the influence of family structure on the utilization of healthcare services among the elderly?
2. What are the effects of step family on the utilization of healthcare services among the elderly?
3. What is the influence of single parent family on the utilization of healthcare services among the elderly?

### **Theoretical Framework**

#### ***Family System Theory***

The word "family" derives from a Latin word meaning household. The concept of family is one with which almost every individual can identify. For some, family means their family of origin; for others, it applies to the family they have biologically created; and for still others, it means the individuals with whom they have developed lasting bonds of intimacy through adoption, foster care, or other relationships. For all of these families, the social and economic foundations that underlie family life are omnipotent. The family is the basic social unit of all cultures, and through time families have remained the most significant institution for nurturing, caring for, and socializing children.

Family systems theory has had a significant impact on the study of the family. It has guided research into such areas as understanding traumatic events or chronic health issues and their impact on individuals and families, substance abuse intervention and treatment modalities, and kinship networks. It has provided a useful lens, through which a greater understanding of families has emerged. Family system theory can be used to explain how family structure and size affects the healthcare utilization of the elderly. A distortion in the structural basis of the family could be inconvenient for the elderly. Family is the basic caregiver of the elderly. Family systems theory exposes how important the family members are to the elderly.

Family systems theory proposes that in a family system, every members of the family play different roles, in other words, family members are directly functional to one another in order to make that order is maintained in the family. For example, a mother in a family is responsible for the caring and

support role in the family, the father is responsible for the control, provision and protective role in the family, the children are responsible for house chores and the elderly is responsible for giving advice in the family.

In contemporary Nigeria, family members have been able to acquire achieved status, thus, they become empowered and are unable to take good care of their elderly much less ensure the provision and the use of healthcare services. Also, members of a family comprise different age groups with different tasks, thus, the elderly sons and daughters provide financial assistance for healthcare services while the younger ones do the home chores at home. In a single parent family, children provide healthcare services to the elderly. This depends on the economic power of the children as well as the living arrangement of the children to the elderly. Healthcare services in a step parent family may come from either the children or the spouse. In the case where the step child is being lackadaisical towards showing care to the elderly, the elderly tends to receive less healthcare services from the step child, thus, healthcare services may come only from their biological children if there is. This may not always be the case as elderly receive healthcare services from their step children if the biological parent is deceased.

In a family, then, a system is something more than parent(s) and child(ren). Significant changes in families include the following: structural changes such as increasing numbers of single parents, including never-married parents, and stepparents; increased visibility of gay and lesbian parents; rising numbers of families from minority populations; a rapid influx of women, including those with very young children, into the paid labor force; increased geographic mobility of young families, resulting in shrinking access to extended family supports; smaller family size, resulting in children as a declining proportion of the population; and delayed childbearing. These changes have brought about expanded definitions of the word "family" and less traditional perceptions about the roles and responsibilities of family members (Turner, Hamner and Orell, 1993). Family systems also are self-reflexive; that is; they have the ability to make themselves and their own behaviour the object of examination and the target of explanation, thereby establishing goals for themselves. This characteristic is what differentiates human from non-human systems.

Family processes, family functioning, family communication and transactional patterns, family conflict, separateness and connectedness among members, cohesion, integration, and adaptation to change--can be understood as the product of the entire system, shifting the primary focus away from individual family members to relationships among the members. Family systems also have subsystems, such as the marital subsystem, one parent and one child subsystem, sibling subsystems, etc. Supra-systems would define families in relation to their extended families, their racial and ethnic subcultures, their geographic regions, and the national system. Subsystems, systems, and supra-systems create a hierarchy.

Family systems take inputs and change them to outputs. The degree and type of inputs is related to the degree of openness or closeness of the system.

There are rules of transformation that take place in the system itself that govern the way inputs are changed to outputs. For example, family systems take inputs in the form of food, various goods and services, information from many sources, and so forth and produce output in the form of behaviours by family members, contributions in the workplace, as well as tangible products such as garbage. Socialized children can be viewed as an output of a family system. This system is capable of regulating its own behaviour because information entering the loop is transformed and ultimately fed back into the loop. Once established, the system maintains a pattern of behaviour determined by one of two particular forms of feedback: positive or negative. Negative feedback loops operate to restore or maintain equilibrium. When any deviation from homeostasis occurs, the system responds by enacting negative feedback to bring the system back to a state of equilibrium. Negative feedback plays a very important role in achieving and maintaining the stability of a system. In families, negative feedback is often seen when change is attempted by one or a few family members. That is, once a family's homeostatic state is established, members will try to maintain their transactional patterns so they can maintain their sense of balance, even if that balance is dysfunctional. All negative feedback loops function to return a family to "the way things were." Therefore, the resistance of the family to change through intervention with a single individual is accounted for by negative feedback (Boss, et al., 1993). When deviation from equilibrium or homeostasis is amplified rather than reduced and more variation in the system occurs, a positive feedback loop has been completed. Systems dominated by negative feedback are characteristically stable and homeostatic. On the other hand, families highly regulated by positive feedback may "run away" with new ideas or behaviours introduced as inputs. Such systems, dominated by positive feedback, show more variability and, if unchecked, tend to be unstable. Thus, healthy families counter positive feedback with negative feedback.

### ***Dependency Theory***

Dependency is a widely used, strongly emotional, but essentially contested concept, especially in the context of elder care. But while 'care' is a heart-warming concept with a positive valence, dependency is cold and its connotations are almost entirely negative. There is ambivalence about acknowledging that dependency is a normal, indeed necessary, social condition. In private life, dependency ties people together. John Donne, the 16th century poet, once declared, "No man is an island." From our very first heartbeat, we are dependent upon another, and we remain dependent to our dying breath. To elucidate the myriad ways people are dependent upon each other would be an enormous task, quite beyond the scope of this manuscript.

In the context of the needs for assistance that arise from physical or cognitive incapacities – the care which Parker (1981) termed 'tending' – it is often asserted that those who depend on care have interests, needs and perspectives that are radically different from the people who see themselves as responsible

for providing it. As argued in this paper, this is because research and theory on dependency and care-giving have emerged from different theoretical paradigms and proceeded along largely separate lines, with little sense that they are exploring and explaining different aspects of the same phenomenon. Research on 'care' has exposed to public gaze and to policy what hitherto has been assumed to be an unproblematic and 'natural' female activity.

Conversely, the disability activists and writers who have promoted a social model of disability have challenged the language of and the policy focus on 'care', as oppressive and objectifying: these perspectives have also recently begun to penetrate academic social gerontology (e.g. Oldman, 2002). 'Dependency' is an equally contested and widely used concept. Although concepts of autonomy and independence have received critical attention, they are nevertheless commonly promoted as the antithesis of dependency and, moreover, as unproblematic and universally desirable goals.

There is no question that aging is marked by progressive deterioration of the body. Many different physiological parameters, such as nerve conduction velocity, maximal heart rate, and muscle strength all drop linearly over the adult lifespan. As the integrity of the body dissipates, the aging adult grows physically weaker, becomes more vulnerable to infectious disease, and falls prey to innumerable chronic illnesses affecting the cardiovascular and skeletal system. On average, select components of memory begin to fade and certain cognitive processes grow sluggish, even in the absence of degenerative brain diseases, such as Alzheimer's dementia. On this basis, elderly will tend to depend on their family members and social support or government for assistance to carry on with their daily life. In this context, elderly will depend on family members and government or social support to receive medical services at their disposal.

The dependency debate examined here is the assumption that dependency is a negative state that should be alleviated wherever possible by public policy measures, treatments or other interventions. In contrast to its historical acceptance, dependency is widely presumed today to be a negative attribute amongst adults, in which psychological and moral failings compound issues of legal, social or economic status. The goal of social, fiscal or other policies is therefore assumed to be the reduction or minimisation of this negative state. Negative connotations are also evident in demographic debates about dependency ratios and overall 'population ageing'. Only rarely is dependency viewed more positively. Applying a typology of dependency to her psychological and social research with older people, Margret Baltes (1996) distinguished structural, behavioural and physical dependency. Although the immediate impact of each of these forms may be to deprive an older person of positive agency, each has a different aetiology and calls for different responses. Moreover, Baltes argued that while it may be desirable to adopt policies and interventions that eliminate structural and behavioural dimensions of dependency, this is not possible with physical dependency. Instead, she argued that to recognise dependency amongst those who need help as a result of age-

related disability is a valuable 'optimising strategy in that it initiates and secures social contact' (Baltes, 1996:5). She further argued that seeking and accepting the help of others should be a positive adaptation strategy which protects and maximises the use of scarce resources and capabilities in other areas of life that have particularly high personal value. In this respect, his rejection of a discourse that emphasises the negative aspects of dependency echoes the feminist writings on the ethic of care that emphasise care as involving the positive interweaving of a 'complex, life-sustaining web' of connectedness between people (Tronto 1993:103).

## **Research Methods**

### ***Study Area***

The study was conducted in Ajah community, Lekki, Lagos State. Ajah is a suburban settlement located in Etiosa East local council development area of Etiosa local Government, of Lagos state. It is bounded in the North by Lagos Lagoon, South by Ikota village adjoining the Atlantic Ocean, east by Sangotedo village and the west by the Aiyetoro Stream. It comprises of three major settlements, Ajah- Makarios, Thomas village and Okera-Addo. The Ajah people are predominantly from the Awori Yoruba subgroup, interspersed with a large immigrant population from different states of Nigeria. The cosmopolitan nature of Ajah also attracts immigrants from the West African sub region e.g. Ghanaians, Liberians, Sierraleonians and others. There is little industrial activity in Ajah, hence the indigenes are mostly fishermen, farmers and traders. However, non-indigene settlers are either white collar workers or entrepreneurs running their own business at different levels. The population of Ajah was estimated to be 1,080,056 by the Etiosa east local government area. It is situated under Eti-Osa, which is one of the official 774 Local Government Areas in Nigeria, of Lagos State, Nigeria.

### **Study Population**

The participants are individual members of the community who are 60 years of age and over, who have worked in any part of the country and have been living in their present abode for not less than five years. This exploratory study utilized key informant interviews to profile the experiences regarding utilization of healthcare facilities by older people in Ajah community.

### **Research Design**

The study was also qualitative and heuristic in nature. An in-depth interview (IDI) guide was designed and utilized to gather information from the key participants. Responses were recorded verbatim and tape recorded with the consent of the participants. The responses on the informants were analyzed and interpreted using content analysis technique. Primary data were therefore qualitative and secondary data were collected through literature and desk reviews.

### Sampling Technique and Sample Size

With the aid of purposive sampling technique, a total of hundred and twenty (120) older persons were recruited for the study which was deliberately spread across the length and breadth of Ajah community in different streets/areas. Community entry process was strategic and systematic by seeking the permission of the community head and stakeholders and this was necessary for a largely homogenous community like Ajah with the help of a resident in the study area, who is known and very knowledgeable about the contours and geography of the area. This gave the needed background working knowledge of the environment.

### Results and Discussion

The narratives from the in-depth interviews shed light on different aspects of the relationship between influence of family structure and utilization of healthcare services by the older persons. Information from the exercise can be deduced into three categories:

**Family network:** The support of family in a large setting will enable elderly to use more of healthcare services. In large families, the kinship ties are highly important, the numbers of family members are much, though, children of the elderly are focused on work and their family but through collective contribution the elderly are being able to receive more care. A significant number of respondents had over five children and use healthcare services through the collective efforts of their children. Moreover, according to one of the participants in the IDI session, she said:

I am 80 years old, I'm married, I'm a Muslim, I did attain formal education, I'm not working, but I receive allowance from my children, any amount per month...God bless me with 6 children...through their assistance, I use healthcare services almost every month, all my children support me individually and sometimes collectively... my children pay for hospital bills and drug, transportation and other expenses. (*IDI/female, 80 years*)

Another female respondent who have 12 children claimed that:

I use modern healthcare services almost every month, all my children support me collectively... my children are of great value and blessings to me. They support me to pay for hospital bills and drug, transportation and other expenses. (*IDI/female, 84 years*)

The assertions above are in support of Silverstein (2006), children serve as a source of care and support for the elderly in any given human society.

**Income relatedness:** Studying elderly from large family unveiled the relatedness of income and the use of healthcare services among the elderly. Due to economic pressures on the children, who have income below their sustenance, elderly people are still able to use healthcare services through their

physical help. In fact, elderly may have more income than the other family members since they get more money from almost all their children regularly, leaving them in position of taking care of themselves and the rest of the family. Thus, the higher the income the higher the elderly chances of using healthcare services. According to respondents who receive thirty-five thousand naira per month claims that:

I go to hospital on appointment basis through my children's driver

I make use of drugs only...sometimes my wife and relatives pay for the use of healthcare services...sometimes my children help with the bills collectively or individually. *(IDI/male, 75 year)*

A respondent in the IDI session asserted that:

I receive income from savings, stipends from volunteering and pension...I receive about 50 thousand naira a month. *(IDI/Male, 68 years)*

In his response to if and how he utilizes healthcare services, he asserted that:

Often go for medical check-up and I use only modern drugs... I pay my medical bills from my income.

From the foregoing therefore, there are income-related differences in utilization of healthcare services among the elderly. Many elderly persons from large family network still access to medical healthcare because the financial capacity of each member of adult children may not be sufficient but they pull resources together to provide healthcare services, therefore, the income of the elderly or caregiver should be sustainable for the use of healthcare services.

**Large family network:** In extended family, the kinship ties are highly important, the number of family members and relatives are more in number, and thus the elderly were able to utilize healthcare services efficiently. A seventy-four (74) year old male respondent who has about 18 family members claimed:

I don't go to the hospital... even if I want to go I have many of my children around me to take me to hospital...but I normally use agbo for malaria, typhoid and jedi-jedi...my children also help in movement and household activities and my relatives also assist me too. *(IDI/male, 74 years)*

Living in multigenerational family system should be viewed not only as a social obligation but also as a useful form of social support to better health related quality of life. A good family support acts as a protection against harmful influence of living in small family that will lead to improve quality of health outcomes. Compared to extended families, elderly people living in small families are much affected by hypertension and poor mental health. This study explains there is a strong association between family structure and health.

***Small Family and the Utilization of the Healthcare Services among the Elderly***

During the IDI session, respondents from small family (such as nuclear family setting) indicated that they tend to focus more on work and their own family than on their elderly. Thus, the elderly have less chances of using healthcare services. A significant number of respondents claimed not to use healthcare services properly, but use traditional medicinal treatment and the use of self-medication. One of the respondents gave a description in the information on the utilization of healthcare services that:

I can't say how many times I go to the hospital but I go only when I am seriously ill and that's once in a while because my adult children's children take priority attention first of all...  
(IDI/Male, 75 years)

The respondents also made mention of the influence of her small family structure on her utilization of healthcare services when asked the question of difficulty in the use of healthcare services

I had very few numbers of children and my children took after me as well. The one and only who I am staying with right now has about three children and they take precedence first and I understand his situation because it is a small family. Otherwise If I have many of them, maybe I will have been receiving a better attention and care.

This study suggests that distinguishing the type of support network a senior has can be helpful in understanding their service use patterns. It is also found that old frail seniors with an attenuated network have a very low rate of utilization even though they may have the highest need. Despite their need, their limited networks may not provide the motivation and means that enable acceleration because the varied communications within their diverse network direct them towards services.

**Little expenses:** In this study, small families have the advantage of having fewer expenses as a result of the fewer family member size. A male respondent who had only one child and wife noted in the IDI session:

I often go for medical check-up...I don't take herbs, I use only 'modern drugs...I pay my medical bills from my income and besides I gave birth to only one child so I have enough, money is not my problem. (IDI/Male, 68 years)

Another respondent who have only 2 children claimed that:

my children are still striving, so it's difficult at times to go to the hospital, buy drugs and others. (IDI/female, 70 years)

Small family members have fewer expenses and can afford to take their elderly to the hospital for medications, and smaller family members with children who are well to do can afford to care for their elderly.

***Nuclear Family and the Utilization of the Healthcare Services among the Elderly***

Information from the narratives concerning nuclear family and the use of healthcare services can be categorized into three factors:

**Living arrangement:** In studying the elderly from nuclear family, it was revealed that elderly prefer to live in or with their children's matrimonial home where they would be properly taken care of. This suggests that that older adults find ways to get around structural barriers, such as geographic distance from a close relative that might upset younger adults. One of them claimed that:

I prefer to stay in my son's house because I believe I will be taken care of...but there are cases when I feel neglected because they are too busy. (*IDI/Female, 69 years*)

This can be related to the study carried by Litwak (2007) that posit that elderly who feel isolated from their children tend to move in with their children in their private houses, to be closer to their children. Hence, older adults may be able to enjoy the positive feelings about the relationship, rather than focus on their inability to visit with the family member in person. However, other studies have agreed with the notion that elderly should live with family members for proper care of the elderly. For example, older people who live far from their grown children still report feeling close to those children and report that their children assist them in different ways.

**Educational benefit:** Many elderly people from the nuclear family are educated. Due to education of the children of elderly and the elderly themselves in a nuclear family tend have positive attitude to health behavior and therefore, use more of modern healthcare services. Therefore, they know the essence and significance of using healthcare services, which explains why a significant number of the elderly in the study use healthcare services properly. A participant has this to share:

My son and his wife are medical personnel, just like most nuclear family members are well educated. Both of them are always teaching me one form of healthy lifestyles or the other.

**Social isolation:** In nuclear family, the kinship ties is less important, the number of family members are small, thus, adult children of the elderly are focused on work and their family which result to less focus on them, although, remittances are being sent to the elderly by those who are married. When asked the difficulty of using healthcare services one of the respondents claimed that:

One of them is social isolation. They hardly have the time to visit or call, they are socially far away too busy except on

holidays when they bring their own children to stay with us for a while.

The assertion above is in line with Rogerson (2003) that as desirable as family care might be, though, in post traditional society children, and especially those with higher levels of education, are miles away from their parents for career reasons and cannot assume daily responsibility for dealing with their parent's immediate needs.

***Step Family and the Utilization of the Healthcare Services among the Elderly***

Information from the narratives concerning step parent family and the use of healthcare services can be categorized into three factors:

**Attitude of family members (especially stepchildren):** the attitude of stepchildren towards caring for the elderly is an important factor in this context. Many elderly bid it comfortable to ask their own biological children rather than stepchildren to help provide healthcare services. Many stepchildren do not see it as a responsibility to take care of their elderly, thus the tendency to use healthcare among elderly that are stepparents is very minimal. Therefore it is imperative to recognize the attitude of stepchildren towards taking care of their elderly to foresee the utilization of healthcare services among elderly. One of the respondents claimed that:

my stepchildren are very far, I see them once in a while, many times they neglect me. *(IDI/female, 72 year old)*

Another respondent claimed that:

My eldest son pays for the use of healthcare services. Sometimes my step children are just there. Sometimes they help but most times they feel less concerned to assist with my health. *(IDI/Female, 68 years old)*

This can be related to Ralf Schwarzer summary of Health Action Process Approach which states that human beings have a set of psychological constructs that motivates to change and how they take preventive action. It describes the attitudinal position of every human towards health behaviour.

**Isolation from caregivers:** it becomes very difficult for elderly to use healthcare services when there is no source. Both biological and step children should be able find time for the elderly to ensure the efficient use of healthcare services. As a 68-year old female respondent stated in her response to the difficulty in using healthcare services:

time makes it difficult, because my children may sometimes not have the time when I need them...I feel lonely most times when they NOT there for me to use health care facility especially. *(IDI/Female, 68 years old)*

***Single Parent Family and the Utilization of the Healthcare Services among the Elderly***

Information from the narratives concerning single parent family and the use of healthcare services can be categorized into three factors:

**Loneliness:** the absence of a spouse may have caused a life of emotional imbalance for the single parent elderly, which is the more reason why most of the respondents suffer from hypertension due to the stress of taking care of the children alone. Also, the possibility that the children will take care of their elderly may be strained due to focus on work, family and attitude of the children, thus the need for a spouse is very crucial. A 68-year old female respondent claimed that:

stress of going to the clinic and attitude of nurses...I lived without a husband all my life, so the stress I went through is my greatest problem as well as loneliness. I am trying to survive in the midst of this economic hardship without any child to lean on and when family members are not there to help. I feel lovely most times. *(IDI/Female, 68 years old)*

**Income Relatedness:** the single parent elderly should be able to derive means from children, relatives and friends in order for the efficient use of healthcare services. Hence, the income of the elderly is an important factor based on this study. One of the respondents advocated in the IDI session that:

also, sometimes I do not want to disturb my son because he has many problems with money, so I shouldn't bother with my health issues, that's when I use herb. *(IDI/Female, 67 years)*

Findings from the study of small family and the utilization of healthcare services among the elderly expose the disadvantage of small family network towards ensuring the use of healthcare services among the elderly; hence the elderly may lack healthcare services because there are not enough family members to enforce the use of medical care for their health sustenance. Also, the income of the elderly is limited because there are few providers of finances, thus, if the elderly or caregiver's income is not dependable to ensure the use of healthcare services by the elderly, it can limit the use of healthcare service of the elderly.

In addition, findings from the study of large family and the utilization of healthcare services among the elderly explain that large family network is a positive derivative of healthcare services through collective and individual contributions of family members. However large expenses of large family may be disastrous because it can limit the use of healthcare services among the elderly. Extended family also has the same advantages and disadvantages but there is a likelihood that the limitation of healthcare services can also be due to low educational status. Most elderly who has an extended family structure are majorly illiterate; thus, there medical care could be limited to the use of traditional herbs and self-medication.

Nuclear families are modern families. These families are entitled to have fewer members, strained kinship ties and can majorly be literate. Fewer family members can be advantageous when the elderly receive more attention due to lesser expenses and disadvantageous when elderly become isolated from family members as they marry or go separate ways.

Single parent family tend to overstressed with the burden of raising their children alone, hence as they grow to become older adult they suffer health challenges like hypertension and heart disease. Also, elderly become more isolated when they detach from their children coupled with the absence of spouse relationship.

Finally, elderly from step parent family may be less likely to use healthcare service if it is left to the stepchildren to take the responsibility. Hence the attitude of the caregiver is also important for the enforcement of the use of healthcare services by the elderly.

In conclusion, family size and family structure, attitude and income of the caregiver are important factors to enforce the use of healthcare services. The educational level of the elderly or the caregiver would determine the attitude towards the use of healthcare services among the elderly.

## References

- Adamchak, D. (1991) Elderly support and intergenerational transfer in Zimbabwe: an analysis by gender, marital status, and place of residence. *The Gerontologist*, 31(4): 505- 513.
- Apt, N.A. and Katila, M. (1994) Generational and intergenerational support: the case of Ghanaian women. *Southern African Journal of Gerontology*, 3(2): 23-29.
- Apt, N.A. (1999) *Coping with Old Age in a Changing Africa*. Aldershot; Avebury.
- Ayranci, U. and Ozdag, N. (2005) Poverty, policy reciprocity and older people in the south. *Journal of International Development*, J Int. Dev. 14: 1143-1151, 2000.
- Brown, C.K. (1999) *Improving the Social Protection of the Ageing Population in Ghana*. Legon: University of Ghana, Institute of Statistical Social and Economic Research.
- Cowgill, D.O. (1986) *Aging Around the World*. Belmont, CA: Wadsworth Publishers.
- Rogerson, F. (2003) Ageing and the Family in the Developing Asia and Pacific Countries. New York: United Nations. 73-75.
- Silverstein, H. (2006) Family Support to the Elderly in International Perspective. In Hall L. Kending, Akiko Hashimoto and Larry C. (Eds.) *Family Support for the Elderly* (Oxford University Press), 293-308.
- Kinsella, K. (1996). "Global Aging: The Challenge of Success," *Population Bulletin* 60(1):3-42.

- Kosberg, A.C. (1992) The Quality of Life of Elderly Living in Institution and Homes in Zimbabwe. *Journal of Cross-Cultural Gerontology*, 2: 345-57.
- Palloni, A. (2000). "Living Arrangements of the Elderly." Paper presented at the United Nations Technical Meeting on Population Aging and Living Arrangements of Older People, NYC: February 8-10.
- Sylvia, B. (2000). "Why we should invest in older women and men: the experience of Help Age International" *Gender and Development*, 8(2): 9-18.
- Litwak, C. (2007). The association of childhood socioeconomic conditions with healthy longevity at the oldest old ages in China. *Demography*, 44(3): 497-518.
- Togonu-Bickersteth, F. (1989) Conflict Over Care Giving: A Discussion of Filial Obligations among Adult Nigerian Children. *Journal of Cross-Cultural Gerontology*, 11: 35-48.
- Troisi, J. (2004). "Ageing in Africa: Older persons as a resource" A paper presented at the International Conference on "Rapid Ageing and the hanging role of the elderly in African households", Organized by the Union for African Population.
- United Nations (1994). *Human Development Report*. New York: United Nations.
- United Nations (2015). Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision*. New York: United Nations.
- UNFPA (1998). *World Urbanization Prospects*. The 1996 Revision No 14. New York: NFPA.
- WHO (2003). Facts about aging. Retrieved from [www.afrowho.int/aging](http://www.afrowho.int/aging) and health 15/03/2014