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Awareness of Hospice Care among Married Adults in Anambra State, Nigeria

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ABSTRACT

The purpose of this survey was to determine the awareness of hospice care among married adults in Anambra State, Nigeria. Two hypotheses guided the study. A sample size of 840 married adult males and females was drawn from a population of 2,796,475 in the three senatorial districts of Anambra State using multi-stage sampling technique. A self-structured questionnaire known as Awareness of Hospice Care Questionnaire (AHCQ) was used for data collection. The reliability of the instrument was determined using Cronbach alpha. Data were analysed using mean and standard deviation, to determine significant difference at 0.05 alpha levels; while inferential statistics of ANOVA and t-test were used to test the null hypotheses on awareness by age and gender respectively. Statistical analysis was performed using SPSS version 20 software. The results among others indicated that married adults in Anambra State were highly aware of hospice care with a grand mean value of 3.18 which falls within the range of high awareness. The result also showed that there were no gender differences between male and female married adults in awareness of hospice care in Anambra State. Finally, there was no significant difference in the mean value awareness of hospice care among married adults in various ages in Anambra State. The study recommended among others that leaders in various communities in collaboration with health agencies should sustain the level of awareness on hospice care through organizing interactive sessions for community members for the benefit of the target group and general population for health promotion.

Keywords: *Hospice care, Awareness, married adults, health promotion, and age*

INTRODUCTION

Hospice care is globally perceived as a type of care that focuses on palliation of chronically terminally ill persons, the elderly persons suffering life –limiting illnesses and the dying. Current research shows that estimates of over 2.5 million people in eight countries of the world are unaware of hospice care. In Nigeria, it is a common knowledge that the elderly with terminal diseases and disabilities are not given adequate care.

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Globally, there is growing interest in the manner in which care is delivered to people prior to the end-of-life to achieve health promotion. This emerged from the fact that many countries of the world are experiencing a health transition from communicable diseases to non-communicable diseases which has become a major health challenge (Joseph, Jayavama & Kotian, 2009). The population of sub-Saharan Africa is ageing and the number of people dying each year is increasing (Abel, Bowra, Walter & Howarth, 2011). According to World Bank (2019), life expectancy in Africa indicated that Nigeria has life expectancy of 53.95, Democratic Republic of Congo 60.03 and Ethiopia 65.57 in 2017 respectively. This presents the need for hospice care for the elderly and the terminally ill in Nigeria as a health promotion agency.

As life threatening diseases transform into chronic conditions, many people would be happier if processes of dying become more elongated. These groups of people with terminal illness perceive their condition as death within years, rather than months, weeks or days. For others, death may still come quickly from diseases, natural and man-made disasters; yet many countries of the world lack the awareness of ways of ageing gracefully and the need to ensure that end-of-life for someone is spent in dignity with quality care; for instance, Nnadi (2019) observed that in Nigeria poor awareness of hospice care make patients report late to hospital at an advanced stage of diseases. This results from the fact that there are some countries where there is neither government policy nor organized palliative care for patients such as Yugoslavia, and in sub-Saharan Africa where such patients usually die at home or in general hospitals where the staff are not able to offer them the proper care (Milicevic, 2002).

Acknowledging the fact that old age and death are inevitable, efforts are geared towards adopting health promotion to achieve longevity. Describing hospice and hospice care, Schulz and Beach (2016) posited that hospice is a philosophy which views death as the final stage of life. Hospice care focuses on patient's comfort and quality of life, rather than curing disease during this final stage of life. Hospice care is generally appropriate for someone with terminal illness, the elderly and individuals with life expectancy of six months or less. Freeman (2013) opined that hospice care begins after the treatment of diseases has ended and when it is clear that the person may not survive the illness. Milicevic (2002) observed that in recent times, hospice care has been regarded as a valuable approach and an aspect of health promotion for the terminally-ill and the elderly. According to Onyeka (2011), hospice care is relatively alien in many parts of the world especially in Nigeria, and it has remained obscure in healthcare programme of Nigeria. Onyeka further explained that, it was recently included in the existing

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healthcare structure in many developing countries of the world, and was formally introduced in Nigeria in 2003, through Palliative Care Initiative of Nigeria (PCIN), now known as center for Palliative Care, Nigeria.

Health is a goal toward which everyone in the world can aspire to reach, and upon which health promotion can be achieved. The inclusion of hospice care in health structure of developing countries encourages health promotion and longevity for all. Health promotion encompasses all activities related to the improvement of health and well-being in the day to day application of health. It enables people to increase control over, improve their health and prolong life among the population as a whole (WHO, 1984 & Onuzulike, 2018). Health promotion services are rendered to the terminally-ill and the elderly through hospice care. Hospice care provides physical, emotional, spiritual and everyday needs of a patient. (International Association for Hospice and Palliative Care (IAHPC), 2010). Hospice care does not only focus on people nearing the end-of-their lives, it takes care of individuals who have life-limiting or chronic illnesses irrespective of age, culture, background or beliefs. Department of Health of End-of- Life Care Strategy (DELCS) (2008) stressed that people who have problems including life threatening disabilities such as Alzheimer's disease, dementia, cancer, HIV and AIDs and other threatening diseases need to be given quality care.

The goal of hospice care centers on quality life for the terminally ill and the elderly. Hence, Igwe and Onuzulike (2019) noted that one of the objectives of hospice care is to enable patients continue pain free-life and manage their symptoms to ensure that the last days of the patient is spent with dignity and quality care. The authors also pointed out that an essential objective of hospice is providing care for the patients and family un-interrupted in patient's home, nursing home, hospital or private hospice. The uniqueness of hospice care is that it is family centred. It is most appropriate for Nigeria culture where patients and the family can be offered health care in their homes, and family members can be involved in taking decision concerning the patient.

The above scenario is often observed among the inhabitants of Anambra State in South East Nigeria, (Onyeka, 2011). Onyeka reiterated that Africans prefer natural prolongation of the dying process and want to be at home so that they can make peace and bid farewell to relatives.

Furthermore, the value of hospice care cannot be overemphasized. The values of hospice care cut across all individuals who have life-threatening or life-limiting illness that can result to the death of persons irrespective of age or beliefs, as well as geographical location. According to Igwe and Onuzulike (2019),

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hospice care guarantees pain free death; as well as providing instructions, assistance and support for the family in times of crisis. Creating awareness on hospice care avails the general public the opportunity to understand the benefits of hospice care and ensure people embrace it.

Awareness is the understanding of a concept, issue or general information. When people have adequate information on hospice care through seminars, interactive sessions, print and electronic media as well as workshops; their health needs will be given attention with regards to quality care, for the elderly and terminally –ill in the society. Mclifratrick et al. (2013) reported that awareness regarding services offered and time of intervention by hospice were very much inadequate in general population as only nine percent of the general population is aware of hospice care in a locality in Northern Ireland. Similarly, Gopal and Archana (2016) found that the awareness of the general population was significantly more among health care workers (75%) compared to the general population. The study also indicated that 72 percent of male respondents were aware of hospice care, while only 44 percent of the females were aware of the same issue. This shows that there is gender difference between male and female variables.

Gopal and Archana also reported that different age groups; 19 – 60years had varied responses on awareness of hospice care among different age groups in general population, while among health personnel, the respondents within the age group 30 -50 years had varied responses on awareness of hospice care. Adewale and Kehinde (2017) noted that awareness of hospice care in Oyo State was low among married adults in all age groups with awareness rate of (31.8%) out of 96 respondents who have ever heard of palliative care when compared to those reported in Western countries. For instance, palliative care awareness rate of 76.3%, 75% and 49% were recorded among Irish, Canadian and Scottish in adult populations respectively (Claxon-Oldfield, Claxon-Oldfield & Rishchynski, 2004).

Adult is regarded as a person 18 years and above according to Nigeria constitution (United Nations International Children Education Fund (UNICEF, 2018). According to Doares (2019), married adults are two adults, aged 18 years and above, who are mature enough to take responsibilities they encounter as husband and wife. For the purpose of this study, married adults between the ages of 20 and 60years and above were used for the study. The age group chosen by the researchers was based on the fact that the lower limit 20 years are likely to be able to manage emotions better with regards to hospice care; while married adults in the upper limit are assumed to have retired from active service and might have

been taking care of their terminally ill and the elderly, though as a routine care which is not recognized as hospice care. This age group was therefore considered by the researchers as the appropriate target population for this study. A married adult may not be aware of hospice care for several reasons which include lack of access to information on hospice and hospice care which poses a great challenge to the general population in developing countries such as Nigeria where culture and tradition are upheld or respected. In support of the above assertion, Milicevic (2002) and World Health Organization (WHO) (2014) reported that over 2.5 million adults in eight countries of the world are unaware of hospice care; some of these countries include Yugoslavia, Hungary, Bravost, Bosnia, Croatia and Bulgaria.

There is paucity of literature on awareness of hospice care in Nigeria. Moreover, hospice care is alien to Nigeria culture especially in South East Nigeria, especially, Enugu, in Enugu State which shares similar culture and tradition with Anambra State where such practices are regarded as a taboo (Onyeka, 2011). In Anambra State, public awareness of the concept of hospice care remains insufficient with its negative health consequences such as increase morbidity and mortality. Dearth of literature may have hindered accessibility of information by the masses on awareness of hospice care in Nigeria. People in Anambra State are tied to their tradition and culture, thereby neglecting some innovations in health care such as hospice care. They believe that, it is the primary duty of the relatives of the terminally-ill, the elderly and the dying to care for them till the end-of-life. Therefore, hospice care is regarded as alien to their culture. Furthermore, hospice care centres might be uncommon in Anambra State, as government and non-governmental agencies are yet to enlighten the masses on awareness of hospice care and to provide such centres to the reach of the masses.

The importance of the present study to married adults in Anambra State cannot be over-emphasized. This study would awaken their consciousness to the benefits of hospice care to the people of Anambra State. Such benefits include; provision of varieties of support services for their sick relatives and the entire family. This study would also assist the terminally-ill, the elderly and relatives in reducing negative emotion associated with caring for such group of people. Equally, provision of hospice care would reduce the financial burden on their relatives by avoiding unnecessary hospital visits and preventing emergency hospital visits.

Life-threatening diseases, life-limiting diseases, terminal illness and dying are horrifying conditions that afflict human race. When such conditions are diagnosed, it destabilizes immediate family members, friends and colleagues.

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Some of the consequences of such health conditions include; physical, psycho-social, emotional and economic problems. Abel, Bowra, Water and Howarth (2011) asserted that the population of the world is ageing and the number of people dying each year is increasing. This necessitates the provision of hospice care for the terminal ill, people with life threatening diseases and the elderly.

The health needs of the elderly, terminally-ill and the dying should include hospice care which focuses on patient's comfort, dignity and quality of care and pain-free death (WHO, 2014). Regrettably, the elderly, terminally ill persons, the dying, and their relatives seem not to access adequate information about hospice care in the general population (Mclifatrick, 2013). This study therefore, was carried out to assess hospice care awareness of married adults in Anambra State, Nigeria. Specifically, the study sought to determine:

1. Awareness of hospice care among married adults in Anambra State, Nigeria;
2. Awareness of hospice care among married adults in Anambra State, Nigeria based on age and;
3. Awareness of hospice care among married adults in Anambra State Nigeria based on gender.

The following null hypotheses were postulated and tested at 0.05 alpha level to give direction to the study:

1. There is no significant difference in the awareness of hospice care among married adults based on age in Anambra State, Nigeria.
2. There is no significant difference between male and female married adults in their awareness of hospice care in Anambra State, Nigeria.

MATERIALS AND METHOD

This study adopted the cross-sectional survey research design. Cross-sectional research design collects data to make inferences about a population of interest at one point in time. The study was conducted in the three senatorial districts of Anambra State which consists of twenty-one Local Government areas. Anambra State is made up of three senatorial districts, namely; Anambra North Senatorial district, Anambra East and Anambra West Senatorial districts. The participants were clustered into three senatorial districts that make up the 21 Local Government Areas in Anambra State. Anambra State shares common boundaries with Delta State to the West, Imo State and Rivers State to the south, Enugu State to the East and Kogi State to the North. The researchers observed that many married adults in the senatorial districts encounter financial and emotional challenges in taking

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care of their aged, the terminally ill and the dying relatives. This predisposes them to severe health complications and early death. Some cultural and traditional practices in Anambra State; such as individuals taking care of their aged and terminally ill relatives; awareness of hospice care could be of benefit to the people of Anambra State. Therefore, the researchers deemed the area appropriate for the study. The population for this study consisted of male and female married adults in twenty-one Local Government Areas in the three senatorial districts in Anambra State; which is estimated to be two million seven hundred and ninety-six thousand, four hundred and seventy-five (2,796,475) (National Population Commission of Nigeria, 2016).

The sample for the study consisted of 840 married adults living in the three senatorial districts of Anambra State. The sample size (840 married adults) was three percent (3%) of the population (2,796,475) used for the study. This was because of the sparsed nature of the communities. Multi-stage sampling procedure was employed in drawing the sample size for the study. In stage one; the participants were clustered into three senatorial districts that make up the twenty-one Local Government Areas in Anambra State. In stage two, six (6) Local Government Areas were drawn using simple random sampling technique of balloting without replacement. In stage three, five communities each was drawn from two senatorial districts, Anambra North and Anambra South senatorial districts; while six communities were drawn from Anambra Central Senatorial district which has the highest number of communities and highest population density in Anambra State (Centre for Community and Rural Development (CCRD), 2019). All were drawn at the rate of one per community from the Local Government Areas, using simple random sampling technique of balloting without replacement. This produced a total of sixteen communities. In stage four, using purposeful sampling technique half (8) of the total communities (16) produced 52 married adult male and female each while, the remaining half (8) communities with high population density produced 53 married male and female adults each. All respondents have experienced or are living with the elderly, the terminally ill relatives and were purposely drawn from the sixteen selected communities. Therefore, 840 were used as the sample size for this study.

Data were collected using researcher-developed questionnaire known as Awareness of Hospice Care Questionnaire (AHCQ). The questionnaire consisted of two sections; Sections A and B. Section 'A' consisted of two question items on personal data of the respondents; variables of age and gender. Section B consisted of eight question items covering the variables on awareness of hospice care as highlighted in research questions. Three experts in health education and

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measurement validated the instrument. The question items were closed-ended and patterned into four choices; Very high, High, Moderate and Low levels of awareness. Respondents were required to tick accordingly and appropriately. Cronbach alpha statistic of external reliability using test-re-test, which involves using the same people, same instruments at different times was used to compute the reliability; and 0.83 was obtained. This was adjudged high and reliable for using the questionnaire for the study.

A total of 840 copies of the questionnaire were administered. Distribution and collection of the questionnaire was done on face-to-face basis by the five researchers with five research assistants and it lasted for six weeks. The researchers also guided the respondents to react to the question items appropriately. This ensured that all the copies of the questionnaire were properly filled and a hundred percent (100%) return rate was achieved.

Data were analysed using both descriptive (mean and standard deviation) and inferential statistics of ANOVA and t-test. Mean and standard deviation were used to determine the respondent's level of awareness; whereas the inferential statistics of ANOVA and t-test were used to test the hypotheses on awareness by age and awareness by gender respectively. The decision rule was based on, when p –value is greater than alpha level at 0.05, it was not rejected; while when alpha level 0.05 is greater than p – value, the result was rejected. The statistical analysis was performed with Statistical Package for Social Sciences (SPSS version 20).

RESULTS AND DISCUSSION

Table 1 shows age and number of the respondents in each age group. Out of 840 respondents, age group 20 – 39 years had 142(16.9%) respondents; 40 – 49years showed 458(54.5%) respondents while, respondents 60 years and above were 240(28.6%). Table 2 shows the frequency distribution of gender of the respondents. Out of 840 respondents, male respondents were 440(52.4%) while, female respondents were 400(45.6%). The results in table 3 present a grand mean value of 3.18 which falls within the range of high awareness; implying that married adults in Anambra State are highly aware of hospice care. Result in table 3 showed that grand mean value of 3.18 falls within the range of high level of awareness and implies that married adults in Anambra State are highly aware of hospice care. The findings of this study are surprising and not expected. This may have resulted from the fact that married adults in Anambra State take care of their terminally ill, the elderly and the dying at home according to tradition and culture of the area. The people in this area regard concept of hospice care as a type of

care given to the elderly, terminally-ill and the dying in their homes in line with their tradition. The result of this study disagreed with the findings of Adewale and Kehinde (2017) who found that awareness of hospice care was low among religious leaders and seminarians in Oyo State compared to those reported among the general population. Furthermore, Cloxon-Oldfield *et al.* (2004) disagreed with the result of this study because they reported that palliative care awareness rate of 76.3%, 75% and 49% were recorded among Irish, Canadian and Scottish adult populations respectively. Golpa and Archana (2016) also reported that awareness of hospice care was significantly more among health care workers (75%) compared to the general population. Furthermore, Mclifatrick *et al.* (2013) disagreed with the findings of this study from the finding that awareness regarding services offered by hospice was inadequate in general population in Northern Ireland. The result of this study also disagrees with the findings of Milicevic (2002) and WHO (2014) who reported that over 2.5 million adults in eight countries of the world are unaware of hospice care; such countries include; Yugoslavia, Bravost, Bosnia and Bulgeria.

The results in table 4 shows the responses on awareness of hospice care among married adults based on age. It revealed that married adults in Anambra State are highly aware of hospice care irrespective of their age. Results in table 4 showed that married adults in Anambra State are highly aware of hospice care irrespective of age. Similarly, results in table 6, implied that there is no significant differences in the mean values of awareness of hospice care among adults of various ages in Anambra State, with p –values that are greater than 0.05 level of significance ($P > 0.05$). The result of this study may have resulted from the fact that all the respondents in the study population share the same culture and tradition.

It was expected that, though all the respondents share common characteristics, variations in age groups which they belong would have shown some variations in response options among the target group. However, experiences gained such as baby care as well as family care rendered by married adults in Anambra State may have contributed to high level of awareness of hospice care. The findings of this study may have been possible as a result of improvement in information technology and accessibility to information on hospice care. Such information must have been accessible to the respondents through available social media platforms; and interactive sessions enhanced through information technology.

The result of this study disagreed with the findings of Adewale and Kehinde (2017) who reported that awareness of hospice care was low in Oyo State among adults in all age groups with awareness rate of 31.8% out of 302

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respondents who had heard of palliative care when compared to the Western countries. However, the findings of this study is in tandem with results of Golpa and Archana (2016) which reported that there is significant difference in responses on awareness of hospice care among adult respondents within the age brackets; 20 – 29 years and 40 -59 years. This disagreed with the result of this study because they reported that different age groups 19 – 60 years had varied responses on awareness of hospice care by married adults in the general population, while among health personnel; the respondents within the age group 30 – 50 years had varied responses on awareness of hospice care.

The result in table 5 shows the responses on awareness of hospice care among married adults based on gender. It revealed that married adults in Anambra State are highly aware of hospice care irrespective of their gender. Results in table 5 showed that married adults in Anambra State are highly aware of hospice care irrespective of their gender. From the ANOVA results shown in table 6 with the p-values greater than 0.05 level of significance ($p > 0.05$), the statement of hypothesis 1 was accepted; implying that there is no significant difference in the mean awareness of hospice care among married adults in various ages in Anambra State.

From the t-test analysis shown in table 7 with the p-values greater than the alpha level of 0.05 ($p > 0.05$), the statement of hypothesis was not rejected; implying that there is no significant difference in the mean awareness of hospice care among male and female married adults in Anambra State.

Results in table 7 also showed that $P > 0.05$ which confirms that there is no significant difference between male and female married adults in awareness of hospice care in Anambra State. The result of this study was not surprising but anticipated. The results obtained in tables 5 & 7, must have emanated from the fact that health and health-related issues are common discuss among health workers and non-health workers which make up the population of this study. Furthermore, improved access to information through social media might have contributed to high level of awareness on hospice care reported in this study irrespective of gender, among married adults in Anambra State. Equally, both males and females in married adult's population may have gained experience in family care practices which may have contributed to high level of awareness reported on both gender. In contrast to the findings of this study, Golpa and Archana (2016) reported that 72 percent of male respondents were aware of hospice care, while only 44 percent of females were aware of the same issue. This shows that there is gender difference between married adult's males and females on awareness of hospice care in the general population in India.

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Table 1: Frequency distribution of age of respondents

S/n	Age of respondents	N	%
1.	20 – 39 years	142	16.9
2	40 -59	458	54.5
3	60years and above	240	28.6

Ta**ble 2:** Frequency distribution of gender of respondents

S/n	Age of respondents	N	%
1.	Male	440	52.4
2	Female	400	45.6

Table 3: Responses on Awareness of Hospice Care among married adults.

S/n	Items	Mean	SD	Remarks
1	Hospice care is the care given to the terminally ill and the dying	3.33	.704	Highly Aware
2	Hospice focuses on patient's quality of life rather than curing disease	3.40	.609	Highly Aware
3.	Hospice care can be provided in a patient's home	3.33	.695	Highly Aware
4.	Children with life threatening illness can benefit from hospice care.	3.21	.746	Highly Aware
5.	Hospice care enables patients experience minimal pain with quality care till death.	2.99	.904	Highly Aware
6.	Hospice takes care of people suffering from chronic diseases such as Alzeihmer's diseases, cancer and HIV/AIDS	2.93	.680	Highly Aware
7.	Chaplains are among the team of professionals who provide hospice care.	3.06	.684	Highly Aware
8.	Hospice care is an essential component of end-of-life	3.26	.778	Highly Aware

Table 4: Mean and Standard Deviation of Awareness of Hospice care among Married Adults in Anambra State Based on Age.

S/n	Items	Age	Mean	SD	Remarks
1	Hospice care is the care given to the terminally ill and the dying	20-39	3.32	.710	Highly Aware
		40-59	3.33	.706	Highly Aware
		>60	3.33	.701	Highly Aware
2	Hospice focuses on patient's quality of life rather than curing disease	20-39	3.39	.607	Highly Aware
		40-59	3.40	.609	Highly Aware
		>60	3.40	.612	Highly Aware
3.	Hospice care can be provided in a patient's home	20-39	3.33	.702	Highly Aware
		40-59	3.33	.694	Highly Aware
		>60	3.34	.696	Highly Aware

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4.	Children with life threatening illness can benefit from hospice care.	20-39 40-59 >60	3.21 3.21 3.20	.742 .747 .750	Highly Aware Highly Aware Highly Aware
5.	Hospice care enables patients experience minimal pain with quality care till death.	20-39 40-59 >60	2.98 2.99 3.01	.903 .909 .896	Highly Aware Highly Aware Highly Aware
6.	Hospice takes care of people suffering from chronic diseases such as Alzeihmer's diseases, cancer and HIV/AIDS	20-39 40-59 >60	2.92 2.93 2.93	.679 .680 .681	Highly Aware Highly Aware Highly Aware
7.	Chaplains are among the team of professionals who provide hospice care.	20-39 40-59 >60	3.05 3.05 3.07	.688 .687 .678	Highly Aware Highly Aware Highly Aware
8.	Hospice care is an essential component of end-of-life	20-39 40-59 >60	3.25 3.26 3.28	.783 .782 .770	Highly Aware Highly Aware Highly Aware

Table 5: Mean and standard deviation on gender response

S/n	Items	Gender	Mean	SD	Remarks
1	Hospice care is the care given to the terminally ill and the dying	Female Male	3.33 3.27	.705 .779	Highly Aware Highly Aware
2.	Hospice focuses on patient's quality of life rather than curing disease	Female Male	3.33 3.40	.705 .610	Highly Aware Highly Aware
3.	Hospice care can be provided in a patient's home	Female Male	3.40 3.33	.609 .698	Highly Aware Highly Aware
4.	Children with life threatening illness can benefit from hospice care.	Female Male	3.34 3.21	.692 .749	Highly Aware Highly Aware
5.	Hospice care enables patients experience minimal pain with quality care till death.	Female Male	3.21 2.99	.745 .904	Highly Aware Highly Aware
6.	Hospice takes care of people suffering from chronic diseases such as Alzeihmer's diseases, cancer and HIV/AIDS	Female Male	3.00 2.93	.904 .678	Highly Aware Highly Aware
7.	Chaplains are among the team of professionals who provide hospice care.	Female Male	2.93 3.06	.682 .684	Highly Aware Highly Aware
8.	Hospice care is an essential component of end-of-life	Female Male	3. 33 3. 34	.684 .778	Highly Aware Highly Aware

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Table 6: t –test analysis on age awareness of hospice care

Items	Sum of Squares	Sum of Squares	df	Mean Square	f	Sig.	Decision
1	Between Groups	.009	2	.004	.009	.991	Not Sig
	Within groups	415.987	837	.497			
	Total	415.995	839				
2	Between Groups	.003	2	.001	.004	.996	Not Sig
	Within groups	311.192	837	.372			
	Total	311.195	839				
3	Between Groups	.004	2	.002	.004	.996	Not Sig
	Within groups	404.995	837	.484			
	Total	404.999	839				
4	Between Groups	.014	2	.007	.012	.988	Not Sig
	Within groups	467.357	837	.558			
	Total	467.370	839				
5	Between Groups	.100	2	.050	.061	.941	Not Sig
	Within groups	684.841	837	.818			
	Total	684.942	839				
6	Between Groups	.029	2	.014	.031	.970	Not Sig
	Within groups	387.395	837	.463			
	Total	387.424	839				
7	Between Groups	.056	2	.028	.059	.942	Not Sig
	Within groups	392.086	837	.468			
	Total	392.142	839				
8	Between Groups	.082	2	.041	.068	.935	Not Sig
	Within groups	507.821	837	.607			
	Total	507.904	839				

Table 7: t –test analysis on gender awareness of hospice care

S/n	Items	t	df	Sig.	Decision
1	Hospice care is the care given to the terminally ill and the dying	.135	838	.892	Not Significant
2	Hospice focuses on patient's quality of life rather than curing disease	.005	838	.996	Not Significant
3.	Hospice care can be provided in a patient's home	-.019	838	.985	Not Significant
4.	Children with life threatening illness can benefit from hospice care.	.035	838	.972	Not Significant
5.	Hospice care enables patients experience minimal pain with quality care till death.	-.102	838	.919	Not Significant
6.	Hospice takes care of people suffering from chronic diseases such as Alzeihmer's diseases, cancer and HIV/AIDS	-.048	838	.961	Not Significant
7.	Chaplains are among the team of professionals who provide hospice care.	-.067	838	.946	Not Significant
8.	Hospice care is an essential component of end-of-life	-.152	838	.879	Not Significant

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CONCLUSION AND RECOMMENDATIONS

This study has both health and educational implications. When married adults are aware of hospice care and its benefits, it will reduce psycho-social, physical and economic problems among the target population in Anambra State and the society at large. This will assist in health promotion of the elderly and terminally-ill as well as the general population. The level of awareness of hospice care among married adults in Anambra State need to be sustained through awareness enlightenment programmes on benefits of hospice care by adopting health education as a veritable tool to achieving health promotion. Finally, it is pertinent to indicate the need for mass education of the Nigeria populace, especially; the health workers to assist in disseminate information on hospice care for many residents of Anambra State who are not aware of hospice care.

This study revealed high awareness of hospice care among married adults in Anambra State, South East Nigeria. Responses also showed that married adults are highly aware of hospice care irrespective of age and gender. Findings also show that there was inadequate understanding of the concept, indicating the need to intensify health campaign to create more awareness on hospice care. Based on the conclusions, the following recommendations were made;

i. Health workers, health agencies, government and non-governmental organizations should intensify effort on health campaign to create awareness on hospice care for married adults and general population for the health promotion of the masses to achieve longevity.

ii. Leaders in various autonomous communities, in collaboration with health agencies should sustain the level of awareness on hospice care through organizing interactive sessions with their subjects on hospice care. Such action would ensure that modern hospice care practices will be incorporated into the culture and tradition in Anambra State in the process of disseminating information to married adults, and the general population for health promotion.

iii. Government and non-governmental organizations such as World Health Organizations, Federal Ministry of Health and United Nations should provide fund and incorporate hospice care into Primary Health Care for easy accessibility and health promotion of the general population.

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