International Journal of Human Kinetics, Health and Education
ISSN: 2449-0326
Vol 11, No1 2026
IJoHKHE

Age and Gender Differences in Dementia Knowledge among Retirees in Enugu State, Nigeria

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Abstract

The study was conducted to ascertain age and gender differences in dementia knowledge among retirees in Enugu state. Three research questions and two null hypotheses guided the study. A cross-sectional survey research design was adopted for the study. The population of the study consisted of the 10,007 retirees in Enugu State civil service. The sample size was 385 (retirees). Dementia Knowledge Assessment Survey (DKAS) Questionnaire was used for data collection. [There was no reliability test on the instrument because it has been previously tested (α=0.85,ω_h=0.87; overall scale) (Annear et al. 2017)]. Frequencies and percentages were used to answer the research questions, while Chi-square statistic was used to test the null hypotheses at .05 level of significance. Results among others indicated that overall 63.9 per cent of retirees possessed low knowledge of dementia, while 28 per cent had moderate knowledge. Majority of the retirees possessed low knowledge of dementia which increases as their ages increased (60-69 years = 59.1%< 70-79 years =65.9% <80 years and above =71.1%). Majority of the retirees possessed low knowledge of dementia with males having slight higher values more than the female retirees (males=65.4%> females =62.4%). Also, at the .05 level of significance, there was no significant difference in the level of retiree's knowledge of dementia according on age and gender. Based on the findings, the author recommended among others that health educators, under the ministry of health should further disseminate information and education about dementia to enhance the low level of knowledge possessed by retirees in Enugu State, potentially through targeted awareness campaigns or educational programmes.

Keywords: Dementia, Retirees, Knowledge, Enugu State

Introduction

Dementia is a global public health challenge, and a leading cause of disability and dependency among older adults, which disproportionately affects people living in low- and middle-income countries, including Nigeria. An estimated 55 million people worldwide are living with dementia, and the figure is projected to triple by 2050 (World Health Organization [WHO], 2021) due to aging populations. Alzheimer's Disease International (2021) reported that an estimated 2.13 million people were living with dementia in sub-Saharan Africa, in 2015, with numbers projected to nearly double every 20 years, increasing to 3.48 million by 2030 and 7.62 million by 2050, with over 367 thousand new cases of dementia annually. In Nigeria, Adeloye et al. (2019) reported the pooled crude prevalence of dementia in Nigeria as 4.9 percent with prevalence significantly higher in women (6.7 %) compared to men (3.1%).

Dementia describes a set of symptoms that can include memory loss and difficulties with thinking, problem-solving or language. It is not a specific disease but it is rather a general term for several diseases that affect the memory. The World Health Organization (WHO, 2023) comprehensively described dementia as a term for several diseases that affect memory, thinking, and the ability to perform daily activities. The agency further explained that dementia is a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (that is, the ability to process thought) beyond what might be expected from the usual consequences of biological ageing. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by changes in mood, emotional control, behaviour, or motivation. National Health Service (2021) explained that the first sign of dementia is usually minor memory problems, but as the condition progresses, memory problems become more severe and further symptoms can develop, such as confusion (disorientation and getting lost in familiar places), difficulty in planning or making decisions, problems with speech and language, problems moving around without assistance or performing self-care tasks, personality changes, such as becoming aggressive, demanding and suspicious of others, hallucinations (seeing or hearing things that are not there) and delusions (believing things that are untrue), low mood or (anxiety).

Certain risk factors increase the likelihood of developing dementia. World Health Organisation (2023) stated that being 65 or older, having high blood pressure (hypertension), high sugar (diabetes), being overweight or obese, smoking, drinking too much alcohol, being physically inactive, being socially isolated and depression may increase the risk of developing dementia. A report by National Institute on Aging (2020) explained that the risk of developing dementia increases significantly with age, with the vast majority of cases occurring in individuals over the age of 65 years. The agency further stated that genetics, lifestyle factors such as diet and exercise, and medical conditions such as diabetes and hypertension similarly, predisposes one to dementia. Additional risk factors include depression, social isolation, low educational attainment, cognitive inactivity, and air pollution (WHO, 2023). It is very imperative that awareness of the life-threatening health problem such as dementia be made known to retirees, as this may lead to early detection and increase their knowledge on the dangers of dementia.

Knowledge possessed by retirees on dementia plays a vital role in adopting the required preventive practices. Knowledge according to Salman (2017), is the theoretical or practical understanding of a subject. It can be implicit (as with practical skill or expertise) or explicit (as with the theoretical understanding of a subject), and it can be more or less formal or systematic. The World Health Organization (2020) also explained that having access to the world's health information and sharing experience are essential for well-functioning health systems. However, there have been several studies conducted on the level of knowledge and awareness of dementia among the public, healthcare professionals, and caregivers. A systematic review conducted in multiple countries, including those in the MENA region, found a general lack of knowledge and awareness of dementia among the public and healthcare professionals (Dahshan et al., 2025). Specifically, the review highlighted gaps in knowledge among healthcare professionals, with 19.9 per cent demonstrating poor knowledge and 11.5 per cent demonstrating good knowledge. Another study found that many people still hold misconceptions about dementia, such as believing that it is a normal part of aging (Pacifico et al., 2022). Another study conducted in the United States found that caregivers of people with dementia had a higher level of knowledge of dementia compared to the general population. The study found that caregivers were more likely to know about the risk factors for dementia, such

as genetics and lifestyle factors, and were also more likely to be aware of available resources and support services (Alzheimer's Association, 2019).

Age and gender are factors that have been implicated in the study of knowledge of dementia. A study carried out in China by Song et al. (2022) on perception and knowledge of dementia prevention and its associated socio-demographic factors reported that older age is associated with a better understanding of dementia risk factors. In a study conducted by Iek et al. (2020) on high school students' knowledge, attitude and preventive practices of dementia care in Macao, knowledge of the female students were significantly higher than the male students. Al-Awad et al. (2024) in their studies also found that women had more knowledge about dementia than men. Yamanea et al. (2021) in their study on survey of dementia knowledge and recognition of dementia prevention and practice in healthy older adults reported that the elderly aged 65-74 years had more knowledge about dementia and more types of behaviour perceived as dementia-preventive as the elderly aged 75 years and older. The authors concluded that healthy older adults were aware of numerous behaviours for dementia prevention and practiced the preventive behaviours. Another study conducted by Suzuki et al. (2020) on dementia-preventing behaviour awareness and uptake rates among Japanese women in midlife; stated that women with greater dementia knowledge also knew more methods of preventing it; however, they were not necessarily implementing the recommended behaviours. The authors recommended that further studies are required to elucidate barriers to engaging in dementia- preventing behaviours despite dementia awareness. In this study, previous studies (Song et al., 2022; Yamanea et al., 2021) indicated that age is associated with risk factors and preventive practices of dementia. Previous studies (Al-Awad et al., 2024 ; Iek et al., 2020; Suzuki et al., 2020) indicated that females have a higher knowledge and preventive practices for dementia, thus this study sought to determine age and gender differences in dementia knowledge among retirees in Enugu State, Nigeria. Enugu State is one of the 36 states in Nigeria. It is located in the southeastern geopolitical zone and was created on the 27th of August, 1991. It is made up of 17 Local Government Areas (LGAs), some of which are in urban and some in rural areas. The state has many retirees that worked in different ministries and establishments before retirement. The retirees are grouped into different pension zones. Some of the zones are in urban areas while others are in rural areas.

In Nigeria, including Enugu State, retirees may experience challenges such as delays in the payment of gratuities and pensions and limited access to quality healthcare services. They may also experience social isolation, cognitive inactivity, depression, and limited educational opportunities, which can affect healthy ageing and may contribute to dementia risk (World Health Organization, 2023). Some retirees engage in unhealthy lifestyle behaviours, including physical inactivity, harmful alcohol or substance use, and poor dietary practices, which are modifiable risk factors associated with dementia. Limited knowledge of the effects of these behaviours on brain health may hinder the adoption of healthier lifestyles. Furthermore, these behaviours can contribute to cardiovascular risk factors, including hypertension, diabetes mellitus, and obesity, which are also associated with increased dementia risk. Therefore, the study specific objectives are to: 1) determine the level of dementia knowledge among retirees in Enugu State and 2) examine whether dementia knowledge differs by age and gender. We hypothesize that there is no significant difference in the level of dementia knowledge among retirees in Enugu State based on age and gender. The study will generate evidence on dementia among retirees in Enugu State. The findings will support the development of targeted health education strategies to improve dementia

awareness, promote healthy lifestyle behaviours, and encourage dementia risk reduction among retirees and within the wider community.

Methods

Study design and setting

A cross-sectional survey research design was adopted in this study. The cross-sectional survey research design is one that produces a snap shot of a population at a particular point in time. Instead of following a group of subjects over a period of time, cross-section of the subjects of varying ages and other socio-demographic factors are sampled and studied at the same time, and data are obtained at one time from groups or at different stages of development (Cohen et al 2018).

The study was conducted in Enugu State, Nigeria among retirees vulnerable to dementia. The study was carried out in Enugu State Nigeria. Enugu State is one of the 36 States in Nigeria. It is located in the south eastern geopolitical zone and was created on the 27th of August, 1991. The State has many retirees that worked in different ministries and establishments before retirement. The retirees are grouped into different pension zones. Some of the zones are located in the urban areas while others are located in the rural areas. In Nigeria including Enugu State, retirees experience challenges such as delay in payment of gratuities, monthly stipends, and lack of access to quality healthcare services. In addition, older adults such as retirees engage in unhealthy lifestyles such as physical inactivity, alcohol and substance use, poor dietary practices which are risk factors for dementia. Also, these lifestyles may result to metabolic risk factors such as hypertension, diabetes mellitus and obesity which are known precursors for dementia.

Study population

The population of the study consisted of the 10,007 retirees registered with Enugu State Civil Service.

Sample size and sampling technique

A sample of 385 retirees in Enugu State was established using Taro Yamane (1967) sample size determination formula.

The multi-stage sampling procedure was used to draw the sample for the study. The first stage involved the clustering of the pension zones into the three senatorial districts in Enugu State (Enugu East, Enugu North and Enugu West). Pension zones in Enugu East are Abakpa, Agbani, Ikem, Enugu zone 1 and zone 2; pension zones in Enugu West are Awgu, Ezeagu, Oji-River, Oversea and Udiwhile pension zones in Enugu North include Enugu-Ezike, Nsukka, Ogbede, New Oversea and Umulokpa. The second stage involved the use of purposive sampling to pick one pension zone from each of the three senatorial districts to ensure that pension zones with greater number of retirees were selected. Stage three involved the use of proportionate sampling technique (73%, 24% and 3%) to select 385 retirees that were used for the study.

Data collection instrument

The instrument for data collection comprised a structured Dementia Knowledge and Preventive Practice Questionnaire (DKPPQ).. The instrument was in two sections: A and B. Section A contained three demographic variables of respondents; age and gender. Section B was the adopted

Standardized Dementia Knowledge Assessment Survey (DKAS) (Wicking Dementia Research and Education Centre, April 2022) with 25 items and non-dichotomous response options of false, probably false, probably true, true and I don't know The respondents were requested to place a tick (√) against the option(s) that best applied to them.

The face validity of the instrument was established by three experts from the Department of Human Kinetics and Health Education, Faculty of Education, University of Nigeria Nsukka. The experts' corrections and suggestions were incorporated to adjust and come up with the final draft of the instrument to be used for the study.

There was no reliability test for section B, standardized DKAS because it has been previously tested (α=0.85, ω_h = 0.87; overall scale) (Annear et al.2017).

Data collection procedure

In order to gain access to the respondents, the researcher presented a letter of introduction obtained from the Head, Department of Human Kinetics and Health Education, University of Nigeria Nsukka to the Chairman of Enugu State Pension Board. The researchers supervised the respondents while completing the questionnaire. Retirees who could not complete the instruments due to one form of disability or the other were assisted to fill the form by the researchers by reading out the questions to them and placing a tick according to the options chosen by the respondent. The completed copies of the questionnaire were collected on the spot from the respondents by the researchers. The researcher visited the pension zones sampled from the three senatorial district and administered the 385 questionnaires to retirees by hand and collected them back after completion on the (spot).

Data analysis

Responses on the questionnaire were checked to ensure that they were properly filled out. Six copies of the instrument were not properly filled out and were discarded. The properly filled copies of the questionnaire were 379 in number and were used for analysis. Statistical Package for Social Sciences version 25 was used for data analysis. Frequencies and percentages were used to answer all the research questions, where < 20 per cent was interpreted as very low; 20-39 low, 40-50 moderate, 60-70 high, 80 per cent and above was interpreted as very high. Chi-square statistics was used to test the null hypotheses at a .05 level of significance.

DKAS Total Scoring Procedure

Step One: In database, DKAS response categories were labeled as follows:

False	1
Probably false	2
Probably true	3
True	4
I don't know	5

Step Two: DKAS data were entered

Step Three: Recode responses to 'false' statements and apply scoring system .The DKAS scoring system is as follows:

2 points were scored for an answer of 'true' to a truthful statement.

2 points were scored for an answer of 'false' to an untrue statement.

1 point was scored for an answer of 'probably true' to a truthful statement.

1 point was scored for an answer of 'probably false 'to an untrue statement.

0 points were scored for an answer of 'true' or 'probably true' to an untrue statement.

0 points were scored for an answer of 'false' or 'probably false' to a truthful statement.

0 points were scored for an answer of 'I don't know'.

Step Four: Items were summed to provide a total score. The maximum total score on the DKAS v2.0 is 50.

Step Five: To calculate subscale scores, the items for each subscale were summed.(see Annear et al. 2017 for subscale items). In order to compare the subscales, you may wish to standardize each subscale to a maximum of 1.

Results

Table 1:**Level of Knowledge of Dementia Possessed by Retirees in Enugu State (n= 379)**

S/N	Items	VLK	LK	MK	HK	VHK
		f(%)	f(%)	f(%)	f(%)	f(%)
1.	Causes and characteristics	125 (33.0)	160(42.2)	59 (15.6)	15 (4.0)	20 (5.3)
2.	Communication and behaviours	79 (20.8)	126(33.2)	124(32.7)	33 (8.7)	17 (4.5)
3.	Care considerations	132 (34.8)	147(38.8)	90 (23.7)	5 (1.3)	5 (1.3)
4.	Risks and Health promotion	59 (15.6)	100(26.4)	129(34.0)	55(14.5)	36 (9.5)
5.	Overall Knowledge	**15 (4.0)**	**242(63.9)**	**106(28.0)**	**7 (1.8)**	**9(2.4)**

Key: 0-19%= Very Low Knowledge; 20-39%= Low Knowledge; 40-59%=moderate knowledge; 60-79%= High Knowledge; 80-100%= Very High Knowledge.

Results in Table 1 show that overall 63.9 per cent of retirees possessed low knowledge of dementia, while 28 per cent had moderate knowledge. Only small proportions (4.0%) had very low knowledge as well as high (1.8%) and very high knowledge (2.(4)%).

Table 2

Percentage Analysis Showing Level of Knowledge of Dementia Possessed by Retirees in Enugu State based on age (n= 379)

S/N	Items	60-69 years (n= 171)					70-79 years (n= 132)					80+ years (n= 76)				
		VLK f(%)	LK f(%)	MK f(%)	HK f(%)	VHK f(%)	VLK f(%)	LK f(%)	MK f(%)	HK f(%)	VHK f(%)	VLK f(%)	LK f(%)	MK f(%)	HK f(%)	VHK f(%)
1.	Causes and characteristics	52 (30.4)	78 (45.6)	22 (12.9)	7 (4.1)	12 (7.0)	51 (38.6)	48 (36.4)	24 (18.2)	6 (4.5)	3 (2.3)	22 (28.9)	34 (44.7)	13 (17.1)	2 (2.6)	**5 (6.6)**
2.	Communication and behaviours	36 (21.1)	61 (35.7)	53 (31.0)	11 (6.4)	10 (5.8)	27 (20.5)	41 (31.1)	45 (34.1)	15 (11.4)	4 (3.0)	16 (21.1)	24 (31.6)	26 (34.2)	7 (9.2)	3 (3.9)
3.	Care cons iderations	55 (32.2)	71 (41.5)	38 (22.2)	4 (2.3)	3 (1.8)	50 (37.9)	54 (40.9)	27 (20.5)	0 (0.0)	1 (0.8)	27 (35.5)	22 (28.9)	25 (32.9)	1 (1.3)	**1 (1.3)**
4.	Risks and Health promotion	21 (12.3)	40 (23.4)	61 (35.7)	31 (18.1)	18 (10.5)	22 (16.7)	35 (26.5)	48 (36.4)	17 (12.9)	10 (7.6)	16 (21.1)	25 (32.9)	20 (26.3)	7 (9.2)	8 (10.5)
3.	**Overall Knowledge**	**6 (3.5)**	**101 (59.1)**	**54 (31.6)**	**4 (2.3)**	**6 (3.5)**	**7 (5.3)**	**87 (65.9)**	**37 (28.0)**	**0 (0.0)**	**1 (0.8)**	**2 (2.6)**	**54 (71.1)**	**15 (19.7)**	**3 (3.9)**	**2 (2.6)**

Key: 0-19%= Very Low Knowledge; 20-39%= Low Knowledge; 40-59%=moderate knowledge; 60-79%= High Knowledge; 80-100%= Very High Knowledge.

Results in Table 2 show that majority of the retirees (59.1%) who are 60-69 years possessed low knowledge of dementia. The percentage proportion of retirees with low knowledge increases as their ages increased (60-69 years = 59.1% < 70-79 years = 65.9% < 80 years and above = 71.1%). On the other hand, percentage proportion of retirees with moderate knowledge of dementia regressed as their age increased (60-69 years = 31.6% > 70-79 years = 28.0% > 80 years and above = 19.(7)%).

Table 3

Summary of Chi-Square Test of Level of Knowledge of Dementia Possessed by Retirees in Enugu State based on Age (n=379)

Variable (age range)	N	VLK O(E)	LK O(E)	MK O(E)	HK O(E)	VHK O(E)	χ^2 value	Df	p-value	Decision
06-69 years	171	6(6.8)	101(109.2)	54(47.8)	4(3.2)	6(4.1)				
70-79 years	132	7(5.2)	87(84.3)	37(36.9)	0(2.4)	1(3.1)	11.864	8	.157	NS
80 years and above	76	2(3)	54(48.5)	15(21.3)	3(1.4)	2 (1.8)				

χ^2 value = Chi Square Statistics; NS=Significant O(E) = Observed frequency (Expected frequency); VLK = Very Low Knowledge; LK = Low Knowledge; MK= Moderate Knowledge; HK= High Knowledge; VHK= Very High Knowledge.

Results in Table 3 show that there is no significant difference in the level of knowledge of dementia possessed by retirees in Enugu State based on age(χ^2= 11.864; *p*-value =.157). Since the p-value of .157 is greater than the 0.05 level of significance at 8 degrees of freedom, therefore, the null hypothesis was not rejected. This implies that no difference existed between the level of knowledge of dementia possessed by retirees in Enugu State based on age.

Table 4

Percentage Analysis Showing Level of Knowledge of Dementia Possessed by Retirees in Enugu State based on Gender (n= 379)

S/N	Items	Male (n= 185)					Female (n= 194)				
		VLK f(%)	LK f(%)	MK f(%)	HK f(%)	VHK f(%)	VLK f(%)	LK f(%)	MK f(%)	HK f(%)	VHK f(%)
1	Causes and characteristics	65 (35.1)	71 (38.4)	33 (17.8)	5 (2.7)	11 (5.9)	60 (30.9)	89 (45.9)	26 (13.4)	10 (5.2)	9 (4.6)
2	Communication and behaviours	33 (17.8)	59 (31.9)	64 (34.6)	19 (10.3)	10 (5.4)	46 (23.7)	67 (34.5)	60 (30.9)	14 (7.2)	7 (3.6)
3	Care considerations	70 (37.8)	68 (36.8)	42 (22.7)	2 (1.1)	3 (1.6)	62 (32.0)	79 (40.7)	48 (24.7)	3 (1.5)	2 (1.0)
4	Risks and Health promotion	31 (16.8)	45 (24.3)	64 (34.6)	25 (13.5)	20 (10.8)	28 (14.4)	55 (28.4)	65 (33.5)	30 (15.5)	16 (8.2)
5	**Overall Knowledge**	**7 (3.8)**	**121 (65.4)**	**47 (25.4)**	**5 (2.7)**	**5 (2.7)**	**8 (4.1)**	**121 (62.4)**	**59 (30.4)**	**2 (1.0)**	**4 (2.1)**

Key: 0-19%= Very Low Knowledge; 20-39%= Low Knowledge; 40-59%=moderate knowledge; 60-79%= High Knowledge; 80-100%= Very High Knowledge.

Results in Table 4 show that majority of the retirees possess low knowledge of dementia with males having slight difference more than the female retirees (males = 65.4% > females = 62.4%). On the other hand, percentage proportion of retirees with moderate knowledge of dementia was more among females when compared to males (females = 30.4% > males = 25.(4)%).

Table 5

Summary of Chi-Square Test of Level of Knowledge of Dementia Possessed by Retirees in Enugu State based on Gender (n=379)

Variable (Gender)	N	VLK O(E)	LK O(E)	MK O(E)	HK O(E)	VHK O(E)	χ^2 value	Df	p-value	Decision
Male	185	7(7.3)	121(118.1)	47(51.7)	5(3.4)	5(4.4)	2.610	4	.625	**NS**
Female	194	8(7.7)	121(123.9)	59(54.3)	2(3.6)	4(4.6)				

Results in Table 5 show that there is no significant difference in the level of knowledge of dementia possessed by retirees in Enugu State based on gender (χ^2= 2.610; *p*-value =.625). Since the p-value of .625 is greater than the 0.05 level of significance at 4 degrees of freedom, therefore, the null hypothesis was not rejected. This implies that no difference existed between the level of knowledge of dementia possessed by retirees in Enugu State based on gender.

Discussion

Results in Table 1 showed that majority of retirees in Enugu State possessed low knowledge of dementia, while few had moderate knowledge. Only small proportion had very low knowledge as well as high and very high knowledge. This result is somewhat unexpected and surprising, as one might anticipate that a substantial proportion of retirees in Enugu State would possess a comprehensive understanding of dementia due to their age. Nevertheless, it shows that there may be no effective educational initiatives or awareness campaigns implemented by stakeholders such as; healthcare professionals, support groups or public health organizations, aimed at raising awareness about dementia within the demographic. This finding agrees with those of Angela et al. (2019) who reported that the overall level of knowledge on dementia among community-dwelling adults and older adults in Macau was (low).

Results in Table 2 showed that majority of the retirees possessed low knowledge of dementia. The percentage proportion of the retirees with low knowledge increases as their ages increased from 60yrs and above. On the other hand, percentage proportion of retirees with moderate knowledge of dementia regressed as their age increased. With corresponding hypothesis in table 3 showing that there was no significant difference in the level of knowledge of dementia possessed by retirees in Enugu State based on age. This finding is unexpected and surprising because, it is assumed that older age should correlate with a higher level of knowledge about age-related health conditions such as dementia. However, it is essential for health education specialists targeted at retirees in Enugu State, to be effective in disseminating information about dementia to this demographic. This finding agrees with those of Yamanea et al. (2021) who reported that the elderly aged 65 to 74 years had more knowledge about dementia than the elderly aged 75 years and older. In other words, as the age increases, the knowledge level decreases. This finding also agrees with those of Ashour et al. (2024) who reported that individuals aged 25-44 had the highest proportion of high knowledge than those aged 45-80 (years).

Results in Table 4 showed that majority of the retirees possess low knowledge of dementia with males having slight difference more than the female retirees. On the other hand, percentage proportion of retirees with moderate knowledge of dementia was more among females when compared to males. With corresponding hypothesis in Table 5 showing that there is no significant difference in the level of knowledge of dementia possessed by retirees in Enugu State based on

gender. This finding may come as somewhat unexpected, as there is often an assumption that knowledge about health-related matters might be more evenly distributed across genders. The lower level of knowledge observed among male retirees could be attributed to various factors, including differences in health-seeking behaviours, access to healthcare resources, or even societal norms regarding health-related education and awareness. This lack of statistical significance may seem surprising given the observed difference in knowledge levels between genders. While the statistical test did not indicate a significant difference, it's essential to consider the practical implications of the observed gender disparity in knowledge levels. This finding agrees with those of Adeloye et al. (2019) who reported that there is no statistically significant disparity in the understanding of risk factors associated with dementia disease among elderly individuals based on gender. It also agrees with Abuawad et al. (2024) who reported that no significant differences in the knowledge towards dementia were found between males and females. This finding disagrees with those of Iek et al. (2020) who reported that knowledge of the female students was significantly higher than the male (students).

Implications of the Findings to Public Health Education

The low levels of knowledge observed among retirees indicate the ineffectiveness of current health education initiatives. However, the low knowledge observed on the two socio- demographics, age and gender highlight the need for more tailored and targeted public health education interventions. Public health education programmes must focus on reinforcing dementia knowledge across all socio-demographic groups. This will help them to be well informed and motivated to adopt preventive practices consistently. Public health education messages should be tailored to address the unique needs and perceptions of different age groups and gender Additionally, public health education efforts should include strategies to enhance the knowledge and preventive practices for dementia among retirees by addressing barriers that might hinder the adoption of the preventive practices.

Finally, the study's result revealed the importance of reinforcing and expanding existing health education initiatives. By addressing gaps in knowledge, public health education initiatives can improve the overall wellbeing of retirees and contribute to better health outcomes of retirees in Enugu State.

Conclusion

The findings of this study indicate that a good number of retirees in Enugu State possessed low knowledge of dementia. The study also found out that the percentage proportion of the retirees with low knowledge of dementia increases as their ages increase from 60yrs and above. Males had the highest percentage proportion of retirees with low knowledge. On the other hand, percentage proportion of retirees with moderate knowledge of dementia was more among females when compared to males**.**

Recommendations

Based on the findings, the following recommendations are made:

1. Health educators, under the ministry of health should further disseminate information and education about dementia to enhance the level of knowledge possessed by retirees in Enugu State, potentially through targeted awareness campaigns or educational programs.

2. There is need for targeted educational interventions channelled to different age brackets to improve the level of knowledge possessed by retirees in Enugu state based on age.
3. Targeted educational programmes or awareness campaigns specifically designed to increase the level of knowledge for dementia among retirees irrespective of gender

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