UNIVERSITY OF EDUCATION, WINNEBA

THE FUNCTIONALITY OF SUPPORT SYSTEMS FOR THE ELDERLY IN GOMOA EAST DISTRICT

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DECLARATION

Student's Declaration

I, VERA ADJOA AKOMANIMAH, declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted either in part or whole for another degree elsewhere.

Signature:……

Date: ……..……

Supervisor's Declaration

I hereby declare that the preparation and presentation of this work was supervised in accordance with the regulations and guidelines for supervision of thesis as laid down by the University of Education, Winneba.

Supervisor's Name: Miss. Ophelia Quartey

Signature: ……..……

Date: ……..……

DEDICATION

This work is dedicated to my dear husband Mr. Isaac Simpson and my lovely children Adjoa Scholar, Wesley and Baaba Akyedepa.

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I want to personally acknowledge the incredible support of Miss Ophelia Quartey and Prof. Samuel Asiedu Addo who have kept the vision alive and have seen this project through a winding road into completion.

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God richly bless you all.

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ABSTRACT

This study sought to investigate the functionality of the support systems for the elderly in Ghana particularly in the Gomoa East District (GED). Purposive sampling technique was used to select the study area whereas snowball technique was adopted for the selection of respondents for the study. In all sixty-four (64) respondents took part in the study. Questionnaires were used to gather data. The study showed that most of the elderly in the area are suffering from low self-esteem, lack of opportunities they had when they were young, health challenges, poverty and loneliness. Additionally, the study revealed that most of the support the elderly receive comes from immediate family members as they find it difficult accessing government support. In terms of treatment given to the elderly, the study showed that most of the children are doing well by returning the help they got from their parents when they were younger. However, the elderly who are unable to receive that kind of support are compelled to work out things on their own in order to make ends meet. From these it was therefore recommended among others that the health insurance policy needs a review especially with the age designated for the aged. A fund be created to help the aged in the society and also, religious bodies need to do more to help the aged with their needs.

CHAPTER ONE

INTRODUCTION

1.1Background of the Study

Ageing is the impact of time on our bodies. It could be defined as the gradual irreversible biological changes that occur in all living things with the passage of time, eventually resulting in death (Biren & Woodruff, 2003). The changes that come with ageing are not only biological but also physical, psychological and social. Implicitly, the elderly suffers physical, social and psychological neglect. Although all organisms age with the passage of time, the rates of ageing vary considerably. There is much heterogeneity in ageing. This proposition indicates that the ageing process is not uniform; individuals age differently from each other. No two people of the same age will pass through the ageing process at the same time or at the same rate not even siblings of the same parentage. The number of older persons in the general population is increasing rapidly in many African countries due to the dramatic gains made in life expectancy during the 20th century. The change in the proportion of the aged is as a result of the advancement in public health, medical and economic technologies over diseases and injuries (Kinsella, 2005).

The issue of ageing became a major concern in Ghana in the late 1980s when the proportion of the aged to the total population started increasing. The proportion of the aged population (aged 60 and older) increased from 5.2 percent in 1960 to 7.2 percent in 2000 (Mba, 2007). The Ghana Living Standards Survey (2008) indicated that the proportion of the elderly (65 years and above) formed 6.3% of the population. Interestingly, in Ghana, elderly persons aged 65 years and above constitute 4.7 percent of the Ghanaian population as indicated by the Ghana Statistical Service

(GSS, 2012), and this figure is noted to be among the highest in Africa as observed by the National Population Council [NPC](2007).Currently, the population of the aged in Ghana is around 1,643,381 (GSS, 2010).

It has been assumed that older people represented only a small proportion of the population in developing countries and that they are adequately catered for within the extended family system (Yeboah, 2011). Mba (2010) has established that both the numbers and the proportion of persons aged 65 and above is growing in virtually all countries. The life expectancy of Ghanaians is increasing and there will be more elderly persons in the society who will need to be cared for. This dramatic increase in the elderly population has raised concerns regarding their health and general wellbeing.

Among humans, the effects of ageing vary from one individual to another. All the physiological changes that occur as a result of ageing are also different from person to person. Stoltz, Udén and Willman (2012) observed that the physical, psychological and the social changes that an individual goes through would not be the same as what another individual would also pass through. The ill-health, hardships and other problems that the aged go through make people perceive ageing as some sort of bane that they have to endure. People who have advanced in age go through a lot of challenges, therefore they need support in diverse ways to make life become comfortable for them (Aboderin, 2004).

The amount and type of elderly care varies from culture to culture. For example, in the developed or Western world, the elderly are considered independent and are expected to take care of themselves. They are left with no clear family support system (Kutner, 1962). Hence, they depend on government support system, social protection, care and support. This situation, according to Kutner (1962) presents a

redefinition and reintegration challenges for the elderly. In Asian countries, for example, the responsibility for elderly care lies firmly on the family (Yap, Thang & Traphagan, 2005).

In Ghana, the challenges faced by the growing elderly population have been documented by many authors (Apt, 2012; Mba, 2007; Van der Geest, 2002). The National Ageing Policy (2010) of Ghana reported that most often the elderly in our society complain of health problems. That is because the immune system gradually loses its ability to fight off infections as we grow older and increases the risk of getting sick which may make immunization less effective as we age (Moses, 2012). As people grow older the ability of their immune systems to fight against diseases decreases. The elderly person's inefficient immunity exposes them to a lot of diseases such as dementia, heart diseases, bones and joints ailments.

Van der Geest (2002) has observed that in Ghana, an increasing aged population is taking place in societies which are least prepared for the challenges that confront the aged. The increased pace of social change has also created the situation whereby caring for the elderly is now considered no more as a family responsibility. According to Quashigah and Attom (2016), some years ago there was a golden age of aging where the elderly were few but held respect and authority in the community and in the family. This is because few people were literate and community traditions were orally transmitted by the elderly. However, the situation is far different today. Due to this, the changing traditional pattern of support for the elderly from the extended family system constitutes serious research concern (Mba, 2007). They are left primarily on their own particularly in terms of social contacts and life satisfactions as

their services are no longer sought nor desired. Adding to this challenge is the fact that preparation for "freedom" of later life is largely left to the elderly person alone.

In Ghana, it has been observed that some of the challenges the elderly face include hunger, health issues, abandonment and loneliness. The elderly need support which could be financial, social or medical care. An attempt is made in this study to bring to light the Governmental care and support that are available for the elderly population in GED and also to analyse in some detail the family support for the elderly.

1.2 Statement of the Problem

It seems there is no functional support system for the elderly in the Gomoa East District (GED). For instance, a lot of elderly people are seen alone in the clinics, marketplaces, on the street and other places looking helpless, weak and unkempt with nobody to help them. Moreover, in the Ghanaian society, traditionally it is the women and girls who prepare meals, care for the sick, do the laundry and support the elderly in the family setting. In the district, however, it is common to see very old men and women struggling to prepare and cook their own food, wash their clothes, and do their own shopping and marketing, all alone. There are a countless number of times that some of these old people are seen begging for alms. Some of them attend clinics all alone with no one to accompany them. One would wonder whether there are no family members to cater for those old people. Casual interactions with some of them revealed that they have many challenges including ill-health and care support. Studies have been conducted on the challenges the elderly in society face and the kind of support they need (Raynes, 2006; Vedel, 2013; Wackerbarth, 2002). However, little has been done to check the functionality of these support systems in the Gomoa East

District, and this creates an empirical gap. In consideration of the above noted gaps, and looking at current trends, it can be said that, little attention has been given to research attempts that seek to investigate care and support for the elderly in the district, and this calls for the need to fill this gap. Caring for the elderly in the Gomoa East District has become difficult and stressful to family members especially to caregivers. Due to this, most elderly persons are left alone to fend for themselves. Old age, which is expected to be the golden period of one's life and supposed to be characterised by tranquillity, enjoyment and satisfaction appears to be full of disappointments and shattered dreams for the elderly. All these instances dawned on the researcher to investigate into the functionality of the support system for the elderly in the district.

1.3 Purpose of the Study

The purpose of this study was to investigate the functionality of support systems for the elderly in Gomoa East District (GED) in the Central Region of Ghana.

1.4 Research Objectives

1. Ascertain the various challenges that the elderly in GED face.
2. Investigate the coping mechanisms adopted by the elderly in GED.
3. Examine the different kinds of support that the elderly in GED receive from their families and the District Assembly.
4. Assess the impression of the elderly about the kind of support given to them by their families.

1.5 Research Questions

1. What are the challenges faced by the elderly in GED?
2. Which coping mechanisms are adopted by the elderly in GED?
3. What kind of support do the elderly in GED receive from their families and the District Assembly?
4. What kind of impression do the elderly have about the support given to them by their family members?

1.6 Significance of the Study

There is paucity of research on elderly care and support systems in Ghana, particularly in the study setting. The results of this study would add to the body of academic knowledge that already exists in the field of elderly support systems for the elderly in Ghana. That is, it would help fill the gap created as a result of little attention being given to the problem of elderly care and support in Ghana.

It has been argued that, a research work should be sufficiently significant to both academicians and policymakers. The study would also be beneficial to individuals and institutions that work closely with the elderly or are interested in their wellbeing. Furthermore, the results of the study would equip stakeholders such as the Ministry of Gender and Social Welfare, the Gomoa East District Assembly, Non-Governmental Organizations such as HelpAge Ghana and other stakeholders. These stakeholders would be better informed about what the elderly go through so as to initiate appropriate welfare policies and programmes to address their challenges. Knowledge of and insights into care and support systems for the elderly would also be

used to direct community-based educational programmes for social welfare and health agencies which provide services to elderly persons who may have experienced neglect.

1.7 Delimitation of the Study

The researcher would have wished to cover a wider scope but due to limited time, funding, the study touched only on the elderly in GED. Content wise, the scope was on the functionality of support systems for the elderly.

1.8 Operational Definition of Terms

Elderly in this context is defined as a person who is 65 years old and above in the Gomoa East District.

Physical neglect in this study means, failing to take care of an elderly person's personal hygiene needs, such as housing needs, good sanitary environment, medical needs and feeding.

Psychological neglect means consistently ignoring or disregarding the elderly person's affectional needs.

Social neglect means failing to provide social contact, activities, or information to the elderly.

Support system means a person or institution providing care to a vulnerable adult as a result of family relationship; or a person and/or institution that has assumed responsibility for the care, welfare and support of a vulnerable adult or the elderly voluntarily, out of sympathy or by contract.

1.9 Organization of Chapters

The five chapter model was used for this study. The first chapter is the introduction aims at justifying the study. It comprises the background to the study, problem statement, purpose and objectives of the study, research questions, significance of the study and delimitations of the study.

The second chapter is the Literature Review. This chapter deals with the theoretical framework that defines the study and a review of related literature by several authorities that justifies the stated objectives of the research.

The third chapter is Research Methodology. The chapter provides information on the research design, participants for the study as well as sampling techniques and procedures used for the study. It also describes the instruments used for data collection, procedures used for data collection and analysis.

The fourth chapter is the presentation of results or findings and discussion. This deals with the presentation of data collected in line with stated research questions. Specific findings were identified, interpreted and discussed in line with previous studies. The final chapter is the summary of findings, conclusions and recommendations for further and future researches.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews theories and literature on age-challenges and coping mechanisms of the elderly. The literature is reviewed under the following themes: theoretical framework, conceptual framework, concept of ageing, age-related challenges, support systems needed by the elderly and coping mechanisms adopted by the elderly.

2.1 Theoretical Framework

Several theories of aging have been propounded to explain the aging process of older persons in society as well as how these processes are interpreted by men and women as they grow old. This is because aging is an interactive process where the individual is affected by the environment while also influencing the environment in which he or she ages. Different theoretical frameworks have been proposed to explain the ageing process, care and support systems of the elderly in the context of this study. These include the Disengagement or Gerontological theory, Engagement or Activity Theory, Continuity Theory, Role Theory, Social Exchange Theory, Cumulative Advantage/Disadvantage theory, Caregiver Stress Theory, Abandonment Theory, Ecological Theory, and Socio-Environmental Theory. Consistent with many research studies regarding aging, these theoretical frameworks are used to explain the phenomenon of elderly care and/or neglect (Burnight & Mosqueda, 2011).

2.1.1 Disengagement or Gerontological Theory

Disengagement theory was formulated by Cumming and Henry in 1961. It postulates that decreasing social involvement is a normal, voluntary part of the ageing process, and one that is mutually beneficial for society and for ageing individuals. The ageing experience from the perspective of the disengagement theorists looks at ageing not as a separate entity from the social system. The disengagement theory of aging claims that elderly people begin to systematically disengage from their previous social roles as they realize the inevitability of death in the near future. The theory further suggests that society responds to the elder's disengagement with a sort of mutual recognition that the elderly will soon pass and society must prepare to function in their absence. As such, the theory argues that it is natural and acceptable for older adults to withdraw from society (Veney, 2001).

Disengagement is a process in which the individual inability to fully coordinate psychomotor activity reduces the number of his or her interpersonal relationships and the quality of those that remain. As stated by Cumming and Henry (1961), intrinsic changes in personality happens in life that allow a person to withdraw psychologically from normative expectations by reducing activity and also decreasing emotional attachment to social objects and actors in preparation for inevitable departure through death. This need is satisfied in the disengagement process because society profits by a proper phasing out of those whose deaths would cause disruptions in the smooth operation of society (Atchley, 1989).

In their assertion, Cumming and Henry (1961) characterize ageing as withdrawal of the individual from society and society from the individual in a mutual fashion. The older generation disengages and seek more passive roles, interacts with

others less frequently and begins to reflect more on the inner self (Burbank, 1986). This view espouses disengagement as a positive adaptive strategy, implying that a person does not have to be "busy" and engaged to be well adjusted during old age (Suhie, 2006).

Disengagement theorists assert that disengagement occurs independently of physical and financial capacities. Thus, as people age, they naturally decrease their social involvement as a matter of choice, not because they become ill, retire, or lose their spouses. The disengagement theory of ageing claims that elderly people systematically disengage from social roles due to the inevitability of death. The disengagement theory of ageing states that ageing is an inevitable, mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system he belongs to. Disengagement theory argues that elderly people begin to disengage from their previous social roles as they realize that they will die in the near future (Hooyman & Kiyak, 2002).

In the opinion of Hooyman and Kiyak (2002), disengagement is not a single event but it is a process that involves a gradual separation of individuals from many positions and roles that they once held. One characteristic of this theory of disengagement is its functional approach that assumes that society must constantly seek equilibrium by meeting the basic needs for survival. It also explains human ageing as an inescapable process of individuals and social structures gradually unlocking and disconnecting from each other in anticipation of the person's death. The authors indicated that aside from societal disengagement, there is also individual disengagement that is usually selective, in that the individual withdraws from certain roles but not from others (Hooyman & Kiyak, 2002). With each withdrawal from a

role, the individual becomes increasingly free and becomes content with symbols of the past ("the good old day's syndrome"). However, norms once internalized can never be eliminated solely because of minimal interaction; neither is disengagement non-competitive because of the desire to return to one's roles during the course of the life cycle.

According to Cumming and Henry (1961), disengagement is an inescapable process in which many of the relationships between an elderly person and other members of society are severed and those that remain are altered in quality. The theory proposes that it is natural for young and able-bodied people to take on the roles of older people as they are pushed out of the system. According to them, a major shift in interaction between elders and society begins once older people fully recognize the brevity of their remaining life span. In general, society tends to distance itself from the elderly as they are taken to be passive and unproductive. It is for this reason that Gubrium (1973) writes that there are two sides to the disengagement process. The individual withdraws from society, just as society also disengages the elderly.

In the same way, Hendericks and Hendericks (1986) support this by adding that society retracts or disengages for social system equilibrating reasons: society disengages so as to introduce younger people into the roles and positions that were occupied by older people who are now not as "useful as they once were." Abidi (1992) argue that growing old involves a gradual and inevitable mutual withdrawal or disengagement that results in decreasing interaction between an ageing person and others in the social system he/she belongs to. It gives the elderly people a new role in life. In other words, rather than for one to be fully engaged in a lot of activities, old age reduces the capacity to fulfil those roles and facilitates disengagement. In

developed or industrial nations where elderly people are beneficiaries of state pensions and grants, disengagement theory does apply. Older people whose job skills degrade voluntarily remove themselves or are removed from the workforce.

However, in developing countries where persons on social security pensions are few, the elderly face a double misfortune as they are pushed out of employment and become vulnerable to the risk of poverty. Many, instead of resting and enjoying a new life as elderly persons, continue to engage in manual labour so as to meet the challenges facing them. This in advanced countries, is termed "roles role". Similarly, high levels of poverty, unemployment and social norms make children heavily dependent on their parents at ages when those parents should be free of such responsibilities. In essence, therefore, the disengagement is compromised in a way. Not surprisingly, Baum and Baum (1980) therefore posit that the theory of disengagement applies appropriately to the relatively healthy and economically secured persons.

This notwithstanding, the theory applies universally to both developed and developing countries (the difference being a matter of time) and for all historical times. Disengagement is inevitable; it is bound to happen sometime in one's future life and it is multi-causal. According to Fry (1992), in every culture and at all times, the society and the individual, prepare for the ultimate disengagement (death) by an inevitable, gradual and mutually acceptable process. From the individual's side, withdrawal is achieved by reduction in the number of roles one plays, a lessening in the variety of roles and relationships and weakening of the intensity of engagement in those that remain. Loss of work is seen to generate a crisis of identity for the elderly

as retirement cuts them off from involvement in the activities of the society, resulting in the dissolution of occupational and community ties.

Victor (1994) posits that from a societal point of view the individual is granted freedom from structural constraints and permission to withdraw. Once set in motion, the process is irreversible and the individual retreats from the social world, which in turn relieves him or her of normative control leaving the individual becoming de-socialized and de-moralized with loss of self-esteem. For the elderly, it is a difficult process but as Burbank (1986) suggests, the process of disengagement is beneficial for the elderly because it helps to engage in activities they prefer. Gubrium (1973) has aptly summarized the features of the theory as one of mutuality, inevitability and universality.

In sum, ageing is well known to be a natural process, which is often a transition from a work-oriented life of partiality, which becomes uncertain during one's latter years. There are two categories of elderly people in Ghana: the young old and the older old. We may apply the activity theory of ageing as highlighted by Diggs (2008), to the first category where old people, apart from inevitable changes in biology and health, seem to be like middle-elderly people with the same psychological and social needs. All things being equal, successful ageing requires sustained social interaction with others. Thus, in the Ghanaian context, the elderly farmer in the rural setting could continue to do his or her farming activity so far as he or she remains strong and healthy.

Nevertheless, the disengagement theory could be applied to elderly men and women in Ghana, who have spent their whole working life in the formal sector until their retirement. In effect, there is a social withdrawal from the wider world. The

disengagement theory assumes that ageing involves a mutual withdrawal that results in decrease in interaction between the elderly and other members of society, especially, for those who have worked for formal organizations.

It is however, noted that the disengagement of the elderly from active social life varies from one environment to the other. There may also be differences in disengagement depending on the type of work one does. People who work in the formal sector are required by law to retire at age 60 while those who work at the informal sector, mostly traders and entrepreneurs, are not age barred as long as they have the strength to work. Normally, roles that are performed by the elderly in formalized institutional structures facilitate the flow of income, which helps to sustain family cohesion. Nevertheless, once the individual starts disengaging in life, stress and pressure set on the individual as he/she starts searching for new ways of self-expression and identity, as well as the maintenance of one's dignity (Titmus, 1989).

2.1.2 Engagement or Activity Theory

Activity theory, which was propounded by Havinghurst (1968), is in contrast with disengagement theory. Activity theory claims that staying mentally and physically active preserves older adults. As it points out to remain active and engage with society is crucial to satisfaction in old age. Havinghurst (1968) supported the theory by arguing that involvement and integration in social networks is positively related to later life satisfaction. Accordingly, the successfully adjusted older person is engaged in life and maintains a high level of social contacts. To maintain a positive self-image, older people must develop new interests, hobbies, roles and relationships to replace those that are diminished or lost with ageing. The theory suggests that older people should continue to be active and resist the limitations brought about by ageing

as long as possible. Havinghurst (1968) further argued that society has been a limiting factor for the elderly because it applies different norms to the elderly and the middle-elderly. The elderly have been regarded as dependent and passive group of people. It is for this reason that Baum and Baum (1980) described optimal ageing as staying active, resisting a shrinking social involvement and finding substitutes for roles, status and activities lost through retirement. This gives the theory an anti-ageing perspective. They further argue that remaining active serves a dual purpose of providing some gratification to the person whilst the community also benefits from improved skills that can be offered.

However, the elderly are in the latter stages of life and do contribute enormously to the solidarity and cohesion of society by providing care to orphans, such as those left behind by the consequences of the HIV/AIDS pandemic (Hooyman & Kiyak, 2002)). If so, society ensures that older people can make a living and sustain themselves even in the absence of a social security system. They can contribute to the improvement of livelihoods. Disengagement from societal roles leads to redundancy and dependency of the elderly. Activity theory by Havinghurst (1968) seeks to prevent that by arguing that activity is preferable to inactivity because it facilitates well-being on multiple levels. This theory is substantiated by the Sustainable Livelihood Approach (SLA) which argues that it is essential for one to have a better and improved livelihood engagement in different livelihood activities.

By taking on different livelihood opportunities, the elderly are able to disprove the assumptions of the disengagement theory. For elderly people in developed countries it may not be necessary to be continually active in the economy. SLA recognizes access to different capital assets as most important for one to be active in

livelihood construction (Hooyman & Kiyak, 2002). Using the assets accumulated throughout the lifespan and their human skills, older people can continue to make a living even in the absence of formal support from the state. This link between SLA and activity theory is vital for conceptualizing the issues of old age poverty and how it can be tackled (Havinghurst, 1968). Critics of activity theory point out that all of the older people will maintain a middle-age lifestyle because of functional limitations, lack of income and lack of the desire to do so. This is particularly true in most African states where old age people have been finding it difficult to compete with other groups in profitable employment. The elderly in their endeavour to be profitably engaged face financial constraints due to their reduced capacity to work and due to stigmatization by society.

Due to loss of physical strength, older persons are increasingly unable to hold their own relations with other groups and this results in withdrawal from societal activities. Elderly people may also lack the motivation and desire to be active as they feel that they have worked long enough and now need to step back and give chance to upcoming younger members of society. Of course health becomes an important consideration for the elderly people in determining their continued engagement in society. Some elderly people disengage from society simply by reason of poor health. Activity theory compliments the continuity theory, which advocates for a continued engagement by the elderly people in their different livelihood enhancing roles.

2.1.4 Continuity Theory

Continuity theory argues that personality, values, morals, preferences, role activity, and basic patterns of behaviour are consistent throughout a life span, regardless of life changes (Schulz, 2006). Atchley (1999) stated that elderly people try to maintain continuity of lifestyle by adopting strategies connected with their past experience. Continuity theory is a modification and elaboration of the activity theory. Activities central to the life course of an individual will still be carried on and or practiced in later life. According to this theory, the patterns of behaviour, traditions and beliefs that were practiced in adolescence and adulthood are likely to continue as old elderly people try to grapple with the challenges of ageing in the face of death. They do not sit and relax to wait for help but, rather, engage in various activities and strategies to ensure that they make a living.

Though most countries have set the ages of 60 or 65 years as retirement age, continuity theory argues that the elderly ignore such "norms" and go beyond these ages to continue in their various activities to ensure and maintain security in later life. Aboderin, (2004) argued that to simply maintain the same standard of living as they grow old, elderly people must rely on pensions, savings and/or their children or other relatives. However, matters differ in developing from developed countries where pensions are in place for the elderly. However, due to increased levels of migration of able-bodied young people, the elderly are left behind to fend for themselves and dependent children. In such circumstances most elderly people continue with different life activities, both on-farm and off-farm strategies, to look after themselves.

The continuity theory therefore, stresses the perpetual involvement of the elderly in making their livelihoods. Continuity and activity theory are intertwined in

the sense that both of them advocate for the full engagement of elderly people in the construction of their well-being and, at times diversify activities.

Although organizations regard the age of 65 as the time for retirement continuity theory notes that elderly people will continue to work even to sustain their livelihoods. SLA recognizes that livelihoods are affected by context. In the context of economic downturn savings and occupational retirement pensions might not be enough to sustain elderly people throughout later life and hence they take remunerative work. These two theories argue that elderly people need to continue to engage in livelihood construction activities to be able to stave off poverty. The main purpose of this study is to explore the strategies which the elderly use and against what limiting factors. Failure to engage in survival activities for many older people will result in dependence on external support.

2.1.4 Role Theory

This is another theory still developing but offers useful insights into the psychological experiences of the elderly. Unlike disengagement that talks of withdrawal from social activities; and abandonment that talks of neglect and isolation of the elderly, role theory tells of the new roles that the elderly have to play with their status. According to Cottrell (1942), these roles are of two kinds. They are:

a. Relinquishing roles and duties that are typically not considered as roles for adults, and

b. "Acceptance of social relations and roles stereotypically" or negatively ascribed to old age.

Implicit therefore, in the role theory is the issue of role change. This means that the individual changes roles as he/she ages. The suddenness of the change is however, crucial for deriving satisfaction and successful adjustment. Phillips (2008) argued that self-conception of being "old" is one critical factor that is related to maladjustment. Since youthfulness is cherished above old age, ageing people tend to have negative thoughts of the roles they have to play as old persons. The elderly are therefore conceived by Phillips (2008), as depriving themselves of greater rewards for the roles played during old age. Rosow (1967), Ochberg, Zarcone and Hamburg (1972) have raised a critical issue of the absence of a clear role for the elderly in Western Societies. Unlike in African societies where older women are naturally expected to help attend to their nursing mothers, older persons to be persons resolving disputes without having to use the courts among others. The elderly in Western societies are left with no clear roles assigned to them. This situation, according to Kutner (1962) presents a redefinition and reintegration challenges where the individual finds it difficult specifying his or her real status in society. Successful ageing therefore depends on one's ability to effectively enact social roles, attitudes and behaviours appropriate to the stage of development – old age.

2.1.5 The Social Exchange Theory

The Social Exchange theory, according to Dowd (1975), is an exchange in which rewards are balanced against costs. Therefore, people continue social interactions as long as they perceive them to be worthwhile. When the exchange between two people becomes unequal and one person is placed in a position of dependence, the power imbalance can be rectified in one of three ways. First, dependent people can extend their network to other members. Second, they can

increase the value of the resources they possess. Thirdly, they can withdraw from the relationship. Dowd (1975) explained that the first two options are difficult for a retired elderly person. They are less likely to have access to a larger network, and they are unlikely to be able to increase the value of their resources because they are retired. Thus, they are most likely to withdraw from the relationship. Each of the theoretical perspectives described above was based upon the idea that as people age, they will have less social interaction.

Dowd (1975) averred that being a member of an association in the religious body or other groups in the society gives them the opportunity to meet and interact with people to break boredom and also enhance their quality of life. He reiterates that it is of great importance that the individual joins a group of interest and attends meetings regularly if their strength would permit them. In his view if for some reasons the individual cannot attend social gatherings, family members should stick close to them as often as possible or once a while take them to social gatherings. He cautioned family members never to deprive them of the access especially if they express the desire.

2.1.6 Cumulative Advantage/Disadvantage Theory

This theory was developed beginning in the 1960s by Derek Price and Robert Merton and elaborated on by several researchers including Dannefer (2000). According to this theory, inequalities have a tendency to become more pronounced throughout the aging process. A paradigm of this theory can be expressed in the adage the rich get richer and the poor get poorer. Advantages and disadvantages in early life stages have a profound effect throughout the life span of the individual. However, advantages and disadvantages in middle adulthood have a direct influence on

economic, social and health status in later life. This theory shows that the older persons who had the opportunity and the advantage in middle adulthood may not experience neglect. However, those who were disadvantageous in their middle adulthood may experience neglect in their later life. This demands review of the Caregiver Stress Theory. This is so because, for most elderly people, neglect occurs when family members caring for them are not able to provide their reciprocal responsibilities.

2.1.7 Caregiver Stress Theory

The caregiver stress theory is noted to be one of the heavily relied upon theories used to explain the cause of elderly care and support or neglect. This theory contends among others that, neglect of the elderly occurs when family members caring for an older adult are not able to manage their care-giving responsibilities well (Wolf, 2000). According to Burnight (2011), the caregiver stress theory fundamentally tends to view the victim as being very dependent on the caregiver who becomes extremely overwhelmed, frustrated, and abusive because of the continuous caretaking needs of the elderly who becomes the care recipient. Implicit in the caregiver stress theory is the notion that, caring for an elderly appears to be a difficult task which tends to elicit a heightened state of mind-body reaction to external stimuli which tend to induce fear and anxiety in the caregiver (Cockerham, 2007). This renders the elderly more vulnerable to neglect.

Critics of the caregiver stress theory are concerned that, it blames victims and legitimizes abusers. For instance, Burnight (2011) observed among others that, caregiver stress theory tends to blame the victims, and does not result in safety for the victim. It can therefore be discerned that, there is some perceived inadequacy in this

theory in trying to explain the etiology of elderly neglect. That is, it tends to blame the neglected elderly rather than the caregiver. This presupposes that, interventions based on this theory are more likely to be skewed in favour of the caregiver. This study does not share the views expressed by proponents. This is because in spite of how dependent the elderly may be on their caregivers, their needs must equally be met by their caregivers. Thus the reciprocal relationship (parent- child contract) must be fulfilled and the inability of caregivers to fulfill this contract result to the breach of the contract. But, while this is an important consideration to be mindful of, it is also important not to overlook stress as a contributing risk factor (Burnight, 2011). As important as the caregiver stress theory is in explaining why caregivers neglect elderly persons, it is not the only theory. This demands further review of the Family Systems theory. This is so because, in Africa and in Ghana it has been observed by the researcher that, caring for the elderly is considered to be a family responsibility and the family is increasingly being affected by the need to provide elderly care, and for many, the strains of doing so result in the neglect of older people.

2.1.8 Abandonment Theory

This theory was initially to explain the neglect of ethnic minority groups in American societies. The theory explains the neglect, isolation and loneliness that older people above 65 years do experience. Baum and Baum (1980), for example, contended that the industrial world of today is a place of ever-changing and new knowledge production. Therefore, the skills and knowledge of the elderly are not very useful to industry. This makes it difficult for older people to be employed to render any service even if they want to. This then leads to a state of deprivation amongst the elderly.

The elderly do not lose out only on the industrial front but also with regards to modernity. Peck (1966) argued that older people lose three key things that are crucial and emphasized by culture: youth, beauty and success. There is no place, therefore, for the elderly in modern society as they are left to float and unattached to others. Barron (1961) has therefore described the status of elderly as an astrictive basis for discrimination. For instance, one's age is a basis for his/her marriage proposals to be refused. Thus, even though in one sense to the theory of disengagement, the distinction lies in the fact that whilst disengagement looks at gradual replacement of roles performed by the elderly, abandonment neglects the elderly. This situation is best described as "roleless' roles.

2.1.9 Ecological Theory

In broad terms, the ecological model explores the interactions between the individual and contextual factors. This model mainly identifies elderly care and support or neglect as an issue which culminates in the complex interplay between the elderly person's personal characteristics, close interpersonal relationships, characteristics of the community in which the elderly person lives or works, and social factors such as policies and social norms (Perel-Levin, 2008).

In effect, the personal characteristics of older persons such as barrenness, widowhood among others and other external or environmental factors such as the relationships which exist between the community and close relations are quite instrumental in the determination of care and support or neglect of the elderly. This posits that, in a situation where the personal characteristics conflict with that of the close relations and the community at large, there is that likelihood of neglect.

2.1.10 Socio-Environmental Theory of Ageing

There have been several competing theories in the field of gerontology and social work. These theories (some of which have been discussed already) have over the years failed to prove to be unable to address all concerns relating the welfare of the elderly. Much more critical is the inability of these theories to fully explain social processes of ageing or to interpret findings of life satisfaction and dissatisfaction in old age (Fry, 1992). The more recent Social Environmental theory presents overarching strengths in that it attempts to examine the relationships and links that exist between ageing individuals and their environment (Lawton, 1980). For theorists in this school, one's ability to interact with one's personal resources and that of the society will to a large extent determine "satisfaction in old age."

The theory assumes that the environment of old age is of two sides and is built on the interrelationships of two dimensions. These two dimensions are the individual context and the social context. The individual context refers to the individual's resources, in terms of health, financial, intellectual, and other social support services, that determine whether the individual chooses to continue with his roles or disengages (Gubrium, 1972; Krampen, 1988). The social context consists of the resources in the society in the form of social protection, residential proximity and norms of age-homogeneity (Fitch & Slivinske, 1989). The theory asserts that the environment of the old is relatively stable compared to the responses of the elderly with a view of changing the social context. Such actions are also altered from one situation to the other. The theory further argues that there is a potential for disengagement, activity, continuity or role change but this potential is of two components; internal and external. The internal component applies to the tendencies for the person to behave in

a relatively fixed way towards other persons, events and activities in the society or environment. The external component concerns the social definitions of behaviour and action expected of old age. The elderly therefore weighs his/her resources, capacities, capabilities, and strengths against the expectations of the old age environment before deciding whether to disengage, continue, be active or change roles. Thus, the theory does not suggest a deliberate action on the part of the elderly to disengage or be actively involved. Instead, such decisions are based on the consideration of the norms of the social conditions.

Life satisfaction, according to the theory depends on the successful interaction between the social resources available in the environment of old age and the resources that can be considered personal to the individual old adult. The differences in resource (individual and social) leads to ageing differences between persons and also affects their capabilities to disengage, be active, continue role or be abandoned. Two critical implications are highlighted by the theory (Baltes, 1999); first, there exists individual development, differences and distinctiveness in terms of capabilities, resources and motivation. These differences make an elderly person opt to be host, locus of reinforcement from the environment, a largely passive person. The second implication is the systemic that exists between ageing persons and their environment and the social change that occurs as a result of attempts by the elderly to change their environment or demand more uniform treatment from the environment. So even though the individual may encounter some forms of abandonment, he/she works to change the norms of society that in one way or the other permits abandonment. The individual's declining level of resources is often linked with declining activity or engagement, and this phenomenon is at variance with societal norms. This theory

therefore presents a more robust approach that is able to highlight many shortfalls of the other theories discussed previously. This is because the social environmental theory can be conceived as circular, compared to the other ones that presents linear arguments about old age discussed by the earlier.

The study was guided by two theories, care-giver stress theory and ecological theory. Care giver stress theory states that neglect of the elderly occurs when individuals or groups who care for the elderly are not able to manage their responsibilities well. The care-givers may think that they are doing their best but out of stress they may overlook certain aspects of care-giving which may be crucial for the elderly. Ecological theory points to the fact that whether the elderly will be cared for properly or neglected depends on some factors. The elderly person's own personal characteristics such as appreciating the care he or she is receiving and his or her preparation towards old age. Another factor is the characteristics of the care-giver, his or her readiness to care for the elderly and knowledge about how to care for elderly persons. There are other factors such as the characteristics of the community, national policies for old people and social norms.

2.2 Conceptual Framework

The conceptual framework utilises a model indicating an issue that bothers on support systems for the well-being and survival of the elderly. This emanates from the challenges which they face and the individual coping mechanisms which they adopt. The conceptual framework showing challenges of the elderly and the support systems as well as coping mechanisms for their wellbeing is shown in Figure 1.

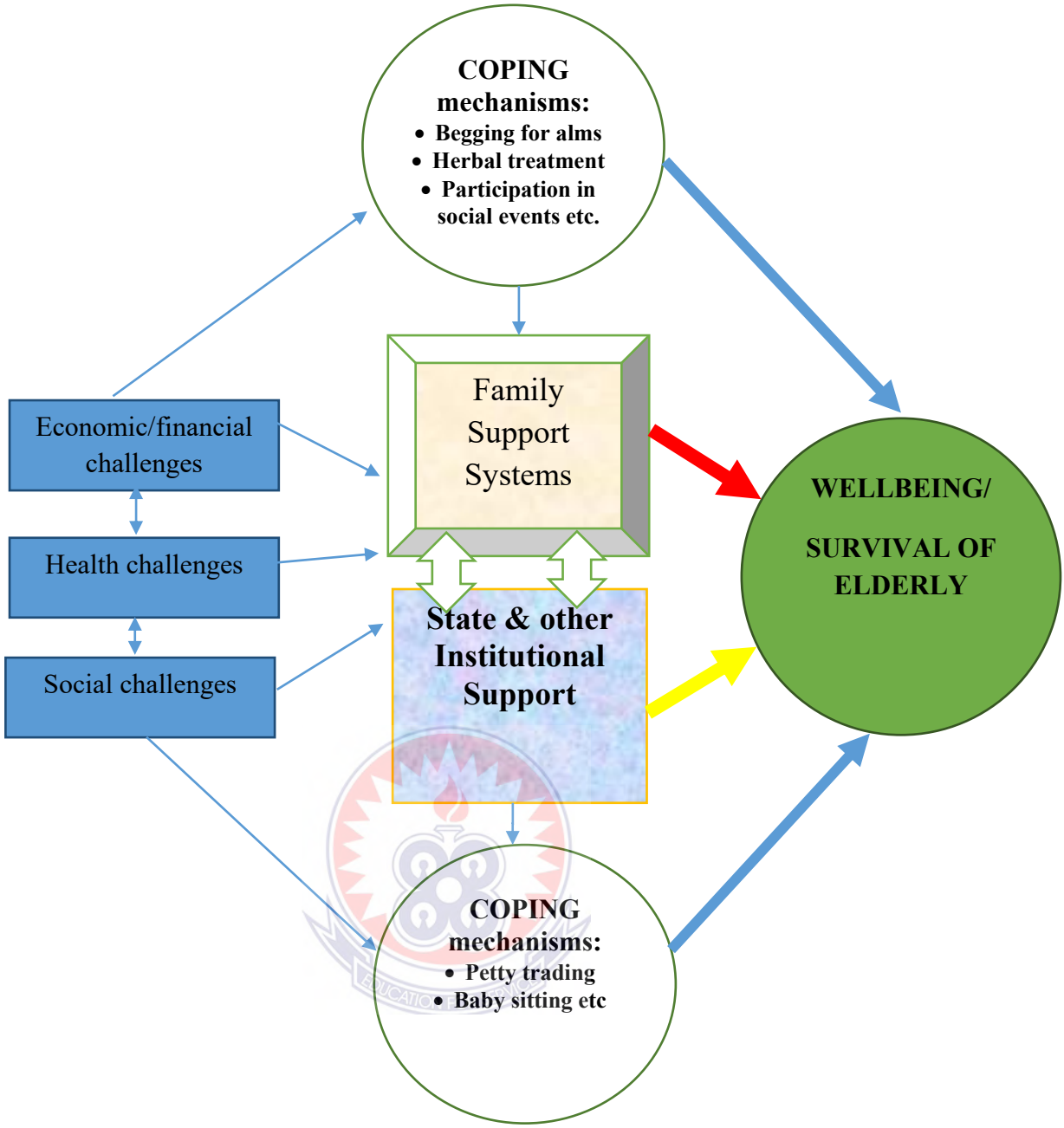

Figure 1: Conceptual framework showing challenges of the elderly and the support systems as well as coping mechanisms for their wellbeing

Source: Researcher's Own Construct

From the conceptual framework, it could be observed that elderly persons face economic/financial, health and social challenges. Some of these challenges include but not limited to financial constraints, hunger, loneliness, and ill-health. Most of these challenges are as a result of physical inactivity, social and economic activity,

poverty, lack of care and support (welfare) for them. In this regard, some of them adopt mechanisms to cope with the situation. Some of these coping mechanisms which they adopt include begging for alms and participation in social activities. This suggests that the elderly require functional care and support systems for their well-being and survival. The support systems are two-fold: informal (family, friends) and formal (institutional) support systems, including both formal and informal institutions such as state institutions like the Social Welfare and Non-Governmental Organisations. According to Suitor, Karl, Shirley and Robertson (1995), family support is often viewed in juxtaposition to state support, within a general division between informal and formal support systems. The relationship between the two is shaped by how much of each is available and/or desirable in a particular context.

2.3 The Concept of Ageing

Ageing is a continuous process from birth to death, encompassing physical, social, psychological and spiritual changes. These changes can be influenced by genetic, environmental and lifestyle factors (Moses, 2012). The World Health Organization has no international consensus for the definition of elderly, other than stating that persons who are 65 years and older are classified as elderly.

Gorman (2000) posited that, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible. Ageing itself is a combination of changes in our body and the impact of what we do with our bodies (Biren & Woodruff, 2003). Whatever we do to the body which include the food we eat, the intensity of thinking or worrying we go through, the body creams we smear

on, the amount of sun rays exposed to the body and many more all affect the ageing process. In the views of Biren and Woodruff (2003), most often we try to do anything possible to retard the rate of ageing. They explained that some people take medicine; others use body lotions on the body and still others eat well, exercise their bodies and do all sorts of things just to impede the processes of ageing yet the unavoidable sets in. The ageing process is a biological reality which has its own dynamics, largely beyond human control.

From 1950 to approximately 2010, the global population of individuals aged 65 and older increased by a range of 5-7 percent (Lee, 2009). This percentage is expected to increase and will have a huge impact on the Dependency Ratio (Bartram & Roe, 2005). Wienclaw (2009) suggests that as health care improves and life expectancy increases across the world, elderly care will be an emerging issue.

Still for practical reasons, statistical definition of old age is usually used in demographic studies, analysis and social policies relating to ageing (Agyemang, 2014). For example, the United Nations World Assembly on ageing held in Vienna 1982 defined old age as those who are 60 years of age and over (UN, 1982). More importantly, as the meanings attached to the concept age change, so do the experiences. For example, in traditional societies, old age and the elderly were conceptualized in terms of experiences and their role in the household, which sometimes extended beyond the family into the community (Agyemang, 2014). It is significant to note that, elderly people's lives are influenced by biological ageing as well as social factors. One social factor is poverty, which can result from their lack of involvement in the labour market compelling them to survive on minimum wages (Calasanti, Selvin & King, 2006; Krekula, 2007).

2.3.1Causes of Ageing

Although the exact causes of ageing remain unknown, scientists are learning a great deal about the ageing process and the mechanisms that drive it. Scientists theorize that ageing likely results from a combination of many factors. The environment, genes, lifestyle and diseases can all affect the rate of ageing (Agarwal & Busse, 2010). The rate of ageing can be inherited and also our way of life can either accelerate or impede the impact of ageing.

Some of the most promising studies on the ageing process focus on the microscopic changes that occur in all living cells as organisms age. Agarwal and Busse (2010) made it clear that in 1965 an American microbiologist Leonard Hayflick observed that under laboratory conditions, human cells can duplicate up to 50 times before they stop. He noted that when cells stop normal cell division (that is Mitosis), they start to age, or senesce. Since Hayflick's ground-breaking observations, scientists have been searching for the underlying cause, known as the senescent factor (SF), of why cells stop dividing and thus begin to age.

Different theories have been proposed to explain how senescent factor works. One theory is based on the assumption that ageing and diseases that occur more frequently with advancing age, are caused by structural damage to cells (Biren & Woodruff, 2003). They further explained that this damage accumulates in tiny amounts each time the cell divides, eventually preventing the cell from carrying out normal functions. One cause of this damage, according to them, may be free radicals, which are chemical compounds found in the environment and also generated by normal chemical reactions in the body. Free radicals contain unpaired electrons and so carry an electric charge that makes them highly reactive. In an effort to neutralize

their electric charge, free radicals constantly bombard cells in order to take electrons in a process called oxidation (Biren & Woodruff, 2003). Free radicals are thought to greatly increase the severity of or perhaps even cause such life-shortening diseases as diabetes mellitus, strokes, and heart attacks. Free radical theories are the aging theories with which the general public is most familiar. Free radicals are by-products of cell metabolism, and they damage other parts of the cell, thus reducing cellular functioning. Free radicals are unpaired electrons, commonly produced during radiation (for example, sun exposure) or oxygenation. Much research has gone into the use of topical or ingested antioxidants to pair with the free radical's electron, thus rendering them harmless (Biren & Woodruff, 2003).

2.3.2 Effects of Ageing

The human body wears out as we grow older. Roth (2012) posits that the human body is like a machine, right from birth the organs in the body are used continually and as time passes the body becomes weak and is not able to work efficiently as it used to be.

Grady and Wallston (2008) outlined three major changes that occur as human beings age. First, the elderly experience biophysical decline that includes their loss of physical strength and functioning, reproductive capacity and become prone to attacks of various diseases. Second, at the psychological level, the elderly at the prime of their maturity suddenly confront the inevitable shrinkage in their goals of life and diminishing self-esteem. Third, sociologically, we know as a person progresses through life, an individual has to perform diverse roles. They experience greater incidence of responsibility, their network of relationship gets wider, and thus, authority and decision taking power of the elderly is at its peak. This process takes an

abrupt reverse turn for an elderly who after a 'cut-off' age has to endure a decline in his/her position, and fails to adjust to such a change.

As we grow older, some functional capacities increase as others diminish (Cutrona & Russell, 2009). When we age, certain useful abilities are enhanced, for example, intellectual abilities, experience, judgement, foresight, ability to handle issues maturely, among others are sharpened as compared to the functional abilities of the younger generation.

Cutrona and Russell (2009), defined it as an expected change with age that is desirable, such as becoming more intelligent, whereas a loss is an expected change that is undesirable, such as becoming less healthy. As we age, the ratio of gains to losses is thought to decrease (Cutrona & Russell, 2009). That implies that as we age, we gain some experiences, wisdom insight into some life phenomena and many more that the young ones usually lack. On the other hand, the aged also lacks physical strength and vitality which are readily endowed with the young generation.

2.3.3 Changes that occur as we age

Gastrointestinal system

The following changes occur in the gastrointestinal system as we age as pointed out by Biren and Woodruff (2003). The tooth enamel thins, saliva production decreases, the taste buds diminish and it begins with those that perceive sweetness and saltiness. Gastric emptying slows, causing food to remain in the stomach longer. Peristalsis and nerve sensation slows in the large intestines, increasing the incidence of constipation. Ageing renders the gallbladder to empty less efficiently. Bile thickens, cholesterol content increases, incidence of gallstones increases. The immune

system loses its ability to fight off infections as you grow older. This increases your risk of getting sick and may make immunization less effective as you age. This is a natural occurrence and cannot be reversed and therefore it is necessary to remain calm and observe good lifestyle practices (Biren & Woodruff, 2003).

Sleep disorders

According to Biren and Woodruff (2003), sleep patterns tend to change as we age. Most people find ageing causes them to have a harder time falling asleep and that they awaken more often. Less time is spent in deep, dreamless sleep. Older people have average 3 or 4 awakenings each night, with increased recall of being awake. Awakenings are related to less time in deep sleep, and to factors such as the need to get up and urinate (nocturia), anxiety and discomfort or pain associated with chronic illnesses. All these reasons cause them to experience sleep disorders. They are often seen dosing off in gatherings such as church, hospitals, in buses, at funerals and the like.

In the views of Biren and Woodruff (2003), sleep disorders whether insomnia, sleep apnoea, or movement disorders all can rob elderly parents of needed sleep. Disruption in sleep patterns can lead to more problems than just making the elderly feel more fatigued.Your body needs sleep to repair and restore itself from the damage of daily living. The lack of sleep increases the risk of almost every major illness. Studies indicate rates of cancer, diabetes, and heart diseases are substantially increased in those suffering from sleep deprivation than individuals who are receiving at least seven consecutive hours of sleep (Biren & Woodruff, 2003). Almost all of the studies conducted to determine the health effects of sleep deprivation on a person have reported lack of sleep will hurt your health. It is alleged that the hormones and

proteins which are believed to have a part in the onset of the chronic health conditions are impacted by a chronic lack of sleep. It is a fact that a lack of sleep interrupts the body's functions and the human body cannot acclimatize or compensate for the lack of sleep.

Female reproductive system

Menopause is a normal part of a woman's ageing process as indicated by Biren and Woodruff (2003). The ovaries stop releasing eggs (ova) and menstrual periods stop. Prior to menopause, menstrual cycles often become irregular. They explained that the ovaries become less responsive to stimulation by follicle-stimulating hormone (FSH) and luteinizing hormone (LH). The vaginal walls become less elastic, thinner and less rigid. The vagina becomes shorter. Secretions become scanty and watery. The external genital tissue decreases. Reproductive system changes are closely related to changes in the urinary system.

Skin

Skin changes are among the most visible signs of ageing as observed by Biren and Woodruff (2003). They explained that the evidence of increasing age includes wrinkles and thinning of skin. Whitening or greying of the hair is another obvious sign of ageing. Changes in the connective tissue reduce the skin's strength and elasticity. This is known as elastosis (solar elastosis). The blood vessels of the dermis become more fragile which in turn leads to bruising, bleeding under the skin (cherry angiomas) and similar conditions. Sebaceous glands produce less oil as you age which makes the skin dry. Women gradually produce less oil during menopause. The sweat glands produce less sweat, this makes it harder to keep cool and they stand at increased risk for becoming overheated. According to WebMD (2012), the skin

changes as one advances in age. It becomes thinner and begins to sag, causing wrinkles. It injures more easily and heals more slowly. The skin also loses its ability to moisturize itself.

Facial movement lines

These lines often known as "laugh lines" and "worry lines" become more visible as the skin loses its elasticity at age 40's or 50's. The lines may be horizontal on the forehead, vertical above the nose, or curved on the temples, upper cheeks, and around the mouth and eyes (WebMD, 2012).

Bone-muscle-joints

Bone mass or density is lost as people age, especially in women later menopause. The bones lose calcium and other minerals. The spine is made up of bones called vertebrae. Between each bone is a gel-like cushion (inter-vertebrae disk). The trunk becomes shorter as the disks gradually lose fluid and become thinner. In addition, vertebrae lose some of their mineral content, making each bone thinner. The spinal column becomes curved and compressed. The shoulder blades (scapulae) and other bones may become porous on an x-ray. The foot arches become less pronounced, contributing to slight loss of height. The long bones of the arms and legs, although more brittle because of mineral loses, do not change in length. This makes the arms and legs look longer when compared to the shortened trunk (WebMD, 2012).

According to WebMD (2012), the joints become stiffer and less flexible. Fluid in the joints may decrease and the cartilage may begin to rub together and erode. Minerals may deposit in some joints (calcification). Hip and knee joints may begin to lose structure. The finger joints lose cartilage and the bones thicken slightly. Finger

joints changes are more common in women and may be hereditary. The muscle fibres shrink. This is more noticeable in the hands which may appear thin and long. With age, bones tend to shrink in size and density which weakens them and makes them more susceptible to fracture. You might even become a bit shorter. Muscles generally lose strength and flexibility, and you might become less coordinated or have trouble balancing.

2.3.4 Contributions made by the Elderly to the Family and Society

The contribution made by the elderly is undoubtedly conspicuous. They are symbol of knowledge and profound experience (Aquino, Russell, Cutrona & Altmaier, 2008). Sometime past, they were seen as a link between the ancestors and the living as they led their communities in performing various traditional ceremonies such as naming and transitional rites, and also prominent roles played during festivals and installation of chiefs. With the performance of such roles, the elderly were held in high esteem. In their view, as society has gone through a series of transformations, so has the position and functions of the elderly changed over the years (Aquino et al., 2008). Prestigious roles of the elderly no longer exist due to modernization, comprising formal education, rural-urban migration, technology, nuclear family systems and urban social ties. This has created a number of negative perceptions particularly on the contribution of the older persons. The elderly are seen as a category of people who are dependent and unproductive.

According to HelpAge Ghana (2005), older persons continue to make vital contributions to the development of the family, community and country. Although the aged lack physical strength and vitality to work assiduously to promote the countries' economy, they contribute immensely to the development of the country especially in

areas such as transfer of knowledge, skills, experience and expertise to younger ones and provide historical facts which help to enrich national debates and shape history. Older persons in so many other ways help to foster national and community cohesion. They also often serve as reliable custodians of tradition and custom. It is important therefore to develop interventions to ensure change in attitudes, policies and practices at all levels in all sectors to address concerns of ageing and promote the positive contribution of older persons in our society.

Traditionally, older persons act as master-craftsmen, handle arbitrations and settle disputes in the communities (HelpAge Ghana, 2005). Through these activities the elderly help to reduce the level of social unrest, civil strife and encourage community development. In recognition of these, to harness their experience and also to provide a better living condition for older persons it is important that government institutes appropriate policies and programmes that would provide support while utilizing the rich resource base of older persons towards national development.

2.4 Challenges faced by the Elderly

Ageing could be seen as a continuous process of change and that change comes with many problems and challenges. It exposes a person to increasing risk of diseases and disability, as the body becomes weak, frail, and not able to perform its tasks as it once did (Hal & Larry, 1992). Old age is feared in recent times; however, this was not always the case. In the good old days, life was not so complicated and family values were given more importance. The older generations used to hold very important position in the family tree and in society. They were the epitome of wisdom. Younger family members benefitted from the profound knowledge and

experiences of their elders. The youth were thus, allowed to be seen in public gatherings but were not to be heard.

The scenario is changing nowadays, with senior citizens being considered as "non-productive" and a social and economic burden (Hal & Larry, 1992). For instance, in urban areas in India, the entire responsibility falls on the male child with whom the ageing parent resides. With the advent of the nuclear family system, the elderly tend to feel neglected when all the others remain busy with their own schedules. The experiences of the old are considered inappropriate in this advanced technology driven world and no one wants to pay attention to what they have to say. The next sections present the economic, social and health changes of the elderly.

2.4.1 Economic Challenges

Many elderly persons live in poverty. A fair number lack adequate food, essential clothes and medicines, and perhaps even a telephone. One of every six of the elderly has incomes close to or below the poverty line. Only a small minority have substantial savings or investments (Johnson & Mommaerts, 2011). People are expected to be less active economically in their old age. They are to continue enjoying from the lifetime savings of their youthful days. This is, however, not the case for all persons. Most elderly persons face grave economic challenges. While some are forced to engage in active economic activity to literally feed themselves, others are forced to sell off their property for their upkeep or to support their children still in schools or under training. Sullivan and Shapiro (2009, p.64) emphasized the importance of financial security for the elderly as follows:

> *Financial security affects one's entire lifestyle. It determines one's diet, ability to seek good healthcare, to visit relatives and friends, to maintain a suitable wardrobe, and to find or maintain adequate housing. One's financial resources, or lack of them, play a great part in finding recreation (going to movies, plays, playing bridge, social gatherings such as funerals etc.) and maintaining morale, feelings of independence, and a sense of self-esteem.*

The statement by Sullivan and Shapiro (2009) presuppose that most of the elderly people face financial constraints. They also reported that majority of the elderly in developing countries face material poverty. Poverty related disadvantages are compounded further for the elderly due to their inadequate social, political and economic participation. This marginalizes them from the mainstream society, which in effect leads to their social exclusion. Poverty resulting in poor housing facility, ill health, and insecurity bring about social inferiority, isolation and vulnerability for the elderly, thus making their infirmities worst. The changing society has also brought some adverse effects on the elderly, typically those in the developing countries (Sullivan & Shapiro, 2009). In their opinion, human history has gone through significant changes giving rise to conditions, which are even difficult to adjust for those humans, who have brought such changes. One such change was transformation of the economy from predominantly agricultural to industrialized form and technology.

In other words, if an elderly person has the financial resources to remain socially independent, having his/her own household and access to transportation and medical services to continue contact with friends and relatives, and to maintain his/her preferred forms of recreation, he/she is going to feel a great deal better about himself/herself and others, than if he/she is deprived of his/her former style of life (Johnson & Mommaerts, 2011).

The economic challenges of the elderly may be linked to early retirement (60). In many occupations, the supply of labour exceeds the demand. An often-used remedy for the oversupply of available employees is the encouragement of early retirement. Forced retirements often create a financial and psychological burden that retirees usually face without much assistance or preparation. Ghana's Social Security programme supports early retirement, which can come as early as age 55 years for men and 50 years for women. Many workers who retire early supplement their pension by taking other jobs, usually of lower status. Nearly 90% of Americans 65 years of age and older are retired even though many are intellectually and physically capable of working. The more a person's life revolves around work, the more difficult retirement is likely to be (Johnson & Mommaerts, 2011). Retirement often removes people from the mainstream of life. It diminishes their social contacts and their status and places them in a situation where they play no role. Individuals who were once valued as sales people, plumbers, accountants, or secretaries are now considered non-contributors on the fringe of society.

2.4.2 Social Challenges

Elderly persons who are single are generally less well off than those who are married. The longer life span of women has left nearly 60% of women over age 65 without a spouse. Zastrow (2004, p.18) comments on the value of marriage for older persons: They now have much more time for and are more dependent upon each other. Some marriages cannot handle this increased togetherness, but those that can become the major source of contentment to both partners… A good marriage, or a remarriage, provides the elderly person with companionship and emotional support, sex, the promise of care if he is sick, a focus for daily activities, and frequently greater

financial independence. Sex roles often blur, and the husband actively helps in household chores.

This statement suggests that the elderly person's life is enhanced in prolonged social relationship, especially in marriage. In the rural Ghanaian context, the elderly usually live with close family members.

Van der Geest (2001) also suggests that there is a common misconception that older people lose their sexual drive. An older male who displays sexual interest is a "dirty old man." Yet many older people have a strong sexual interest and a satisfying sex life. The attitudes of the younger generations frequently create problems for the elderly. A widow or widower may face stiff opposition remarrying from other family members. For example, most Ghanaian children will prefer their widowed parent to remain single. Negative attitudes are often strongest when an elderly person shows interest in someone younger and who will become an heir if the older person dies. However, it appears attitudes toward sexuality in later adulthood are changing. In the opinion of Van der Geest (2001), the elderly also experience isolation and sometimes neglected by society. In the advanced world, most persons reduce their guilt by sending their old parents to care homes created specifically to care for the elderly. However, seldom do these children realize that although their parents or grandparents may get physical care in these institutions, their emotional needs of affection and love by their own, near and dear ones remain unfulfilled (Van der Geest, 2001). What most youngsters of today fail to realize is that they too will get old too some day and may have to meet a similar fate, because history is bound to repeat itself and a person "reaps what he sows".

Sometimes, family members, the society and even the elderly themselves see themselves as not being useful any longer (Bartram & Roe, 2005). People fail to appreciate the usefulness of the elderly. Aquino et al. (2008) suggested that there is no greater tragedy for the elderly than the unnecessary sense of uselessness which society now imposes upon them prematurely. Surprisingly, the elderly themselves are often the most rigid adherents to these negative stereotypes about old age. Believing they are incompetent, the elderly may become less effective in their actions and conform to social stereotype.

Knowing that they are valued by others is an important psychological factor in helping the elderly to forget the negative aspects of their lives, and thinking more positively about their lives and their society. Social support does not only help improve a person's well-being, but also affects the immune system as well. Thus, it is also a major factor in preventing negative symptoms such as depression and anxiety from developing as stated by Aquino et al. (2008).

The assurance of worth from others such as positive reinforcement can inspire and boost the self-esteem of the aged. Aquino et al. (2008) explained that when the aged realize that they are not seen as a burden to the family members or the society but rather seen as great assets that the society can depend on for something profitable, they become inspired. Family members should not regard the aged as people of no importance but constantly assure them of their worth to the family or the society since they are not dead yet. Appreciate their little effort they try to put up.

According to Aquino et al. (2008) a great harm would be caused when the aged realize that care-givers are tired of them (Aquino et al., 2008). They lose all hope and even wish for death. Unfortunately, Ghana and many other African countries have

accorded relatively low priority in their national policies to the aged of their populations (Aquino et al., 2008). One of the major concerns of older persons in Ghana is the absence of a comprehensive, coherent and well-articulated policy document on ageing.

2.4.3 Loneliness

Today, the media frequently present stories of lonely and destitute old people, who have been abandoned by family members and also stripped off their feelings of personal wealth and usefulness. Stoltz et al. (2012) state that many older people live alone and have few friends or relatives. Without the company of others, days can seem long and empty for the elderly. In today's busy society, those who work lead increasingly pressurized lives with little spare time. Older people are becoming increasingly marginalized and many are desperately in need of contact with others from family, friends, the community and the nation. Social isolation is one of the most frequent reasons why older people become ill and have to go to hospital. Without someone to talk to, everyday problems and concerns can be magnified out of all proportion and can lead to depression.

A simple act of friendship can make all the difference. Bowling (1997) asserts that marital status of the aged is another factor that weakens the position of the elderly within the greater society. Loss of married partners has different impact on men and women. On one hand, men suffer from loneliness and lack of support that they found readily available all their life. On the other hand, women are distressed by the inevitable destitution that they have to experience because of their perennial economic dependence on their male partners.

2.4.4 Health Challenges

According to Aquino et al. (2008), the physical functioning of older adults usually weakens as they become older. It is the key factor in predicting the health outcome of older adults in their status at the time they retire. The body and immune system of older adults usually become fragile as they become older, therefore, they tend to depend more on assistance from family members. In most foreign countries, homes for the elderly or the aged have been provided to offer assistance to those who are very old and can do almost nothing by themselves (Aquino et al., 2008). In such places, the aged have the opportunity to converse with their peers so that they will not feel lonely or rejected. There is the need for people to take the necessary measures to make ageing blissful rather than despicable for them. It is very important that individuals plan very effectively toward old age so that it does not become as an unpleasant event.

Good health is very vital in the life of every individual. It is an element of human capital in carrying out survival strategies or activities. Most elderly people with deteriorating conditions struggle, as they cannot engage in many activities. The World Health Organization (WHO) defined health as a state of complete physical, mental and social well-being, and not merely the absence of diseases or infirmity (World Health Organization, 2006). Muruviwa, citing Suhie (2006) explains a person's health in terms of the person's biography or product of his /her life story, which helps one to understand the health and health needs of older people. Studies from most developing countries, show that when elderly people are in good health, they continue to work while those who are ill end up in poverty when support from

household members is insufficient (Muruviwa, 2011). The elderly people's inability to access healthcare in Africa has been attributed to their low-income levels. In most cases, lack of access to healthcare in most developing countries has left the elderly vulnerable to sicknesses and diseases as they lack the means to pay for treatment that they need. Due to this, they have resorted to traditional medicine and faith based healing and informal health.

According to Twumasi (1975), most African countries have pluralistic medical system, with traditional and Western healers operating side by side. Since most elderly persons reside in rural areas, they tend to rely on traditional medicine to meet their health care needs. However, empirical evidence on access to health care services in a number of Ghanaian communities shows that rural dwellers have less access to health services than their urban counterparts (Apt, 1992; Banga, 1992).

According to Moses (2012), the aged are faced with numerous health related problems such as dementia, sleep disorder, gastrointestinal disorder, joint problems, cardiovascular diseases and many more. By one definition, ageing refers to a progressive loss of the ability to adapt so that the individual becomes increasingly less capable of coping with life challenges (WHO, 2006). Studies in developed countries have shown that up to 40% of persons over the age of 65 suffer from a chronic illness or disability that limits their daily activities (Roth, 2012). Older people have limited regenerative capabilities and are more prone to diseases, syndromes, and sickness than other age groups.

There is often a common physical decline, and people become less active. Good health is vital for economic growth and the development of societies. Older people's capacity to earn a living and participate in national development, and

community and family life to a large extent depend on their state of health. Though older persons are fully entitled to have access to preventive and curative care, including rehabilitation and general health care, they are often denied.

The situation is due to the limited number of health providers in rural areas and the disproportionate amount of public funding to urban heath care. The lack of guaranteed health care for the elderly has contributed to poor access and utilization of formal services. Thus, poor elderly Ghanaians continue to be the most vulnerable. Examining the health status of the elderly from a gender perspective, Apt (1994) reports that there are more women with arthritis (33%) than men (28.5%) in similar rural situations. A study by Banga (1992) also revealed the following health challenges for old elderly: poor eyesight, pelvic pains, diabetes, and difficulty in walking. Another study, by Twumasi (1975), identified the following health problems of the elderly: high blood pressure, poor eyesight and knee problems.

Twumasi (1975) reveals that the majority (78%) of the elderly did go to hospital when sick. However, since health services are expensive, lack of funds and long periods of taking medicine with no improvement made them discontinue accessing health care facilities. Perhaps what the government can do is to lay strong emphasis on free health care for the elderly.

Thus, in rural areas, as many as 68% of the elderly could hardly afford the payment of hospital bills and therefore resorted to self-medication or the use of herbal medicine (Twumasi, 1975). The introduction of the Health Insurance Scheme in 2003 has helped in addressing this problem, even though many challenges still exist. The challenge today is to develop a health system that offers equitable access for all elderly people in the country. A critical analysis of the literature shows that a barrier

to obtaining access to healthcare is poverty. Consequently, most elderly people cannot afford the most basic healthcare (World Bank, 1993). In general, resource constraints have prevented health policy makers from extending healthcare services to rural areas equivalent to those in the urban areas. While a sizeable proportion of the elderly live in rural areas, most modern healthcare facilities are located in urban centres.

A disproportionate proportion of the health budget is spent on urban health services. This limits access to healthcare for rural elderly Ghanaians (World Bank, 1993). According to the report, the refusal of some hospitals to accept national health insurance cards, and charging user fees, a practice known locally as **"**cash and carry**",** has contributed to this access problem. Despite much talk about institutionalizing some healthcare for the elderly, this policy is yet to be fully implemented. The challenge today is to develop a healthcare system that is easily accessible to the elderly in Ghana.

Older people are more likely than young people to worry about their health, and for good reasons. The elderly are much more likely to suffer from chronic diseases, that is, diseases for which there is no cure. These health problems limit their daily activities. Research indicates that among the elderly people, 75 or older, one-third report that their health is fair or poor (National Academy on ageing Society, 1999). Behaviours such as smoking and drinking may predispose elderly people to diseases, while exercise may improve their health. Thus, people who engage in unhealthy lifestyles when they were young, smoking and drinking and never exercising, may pay a price in the form of heart disease, lung cancer or emphysema when they are old (Quadagno, 2002). Other factors that contribute to poor health later in life are beyond a person's control. Although an individual's resources influence

access to health care and the quality of care available, social factors also influence the way societies organize their resources to deal with health hazards and deliver medical care (Quadagno, 2002). Cultural and political values affect both the organization of the health care system and the levels of funding for health care services (Cockerham, Abel, & Lueschen, 1993 as cited in Quadagno 2002).

According to Quadagno (2002), old age is a social problem partly because of the high costs of health care. Most of the elderly have at least one chronic condition, and many have multiple conditions. The most frequent health problems are arthritis, hypertension, hearing and visual impairments, heart disease, orthopaedic impairments, sinusitis, cataracts, diabetes, and tinnitus. The medical expenses of an elderly person average more than four times those of a young adult. This is partly because the elderly suffer much more from long-term illnesses, such as cancer, heart problems, diabetes, and glaucoma.

Of course, the physical process of ageing contributes to health problems. However, research in recent years has demonstrated that social and personal stresses also play a major role in causing diseases. The elderly face a wide range of stressful situations: loneliness, death of friends and family members, retirement, changes in living arrangements, loss of social status, reduced income, and a decline in physical energy and physical capacities. Medical conditions may also result from substandard diets, inadequate exercise, cigarette smoking, and excessive alcohol intake (Quadagno, 2002).

According to Quadagno (2002), the older person is often a lonely person and so are sometimes neglected by society. He explains that most elderly people 70 years of age or older are widowed, divorced, or single. When someone has been married for

many years and his or her spouse dies, a deep sense of loneliness usually occurs that seems unbearable. The years ahead often seem full of emptiness. It is not surprising, then, that depression is the most common emotional problem of the elderly. Symptoms of depression include feelings of uselessness, of being a burden, of being unneeded, of loneliness, and of hopelessness. Somatic symptoms of depression include loss of weight, fatigue, insomnia, and constipation. It is often difficult to determine whether such somatic symptoms are due to depression or to an organic disorder. Depression can alter the personality of an elderly person. Depressed elderly people may become apathetic, withdrawn, and show a slowdown in behavioural actions. An elderly person's reluctance to respond to questions is apt to be due to depression rather than to the contrariness of old age. Those who have unresolved emotional problems in earlier life will generally continue to have them when older. Often these problems will be intensified by the added stresses of ageing (Quadagno, 2002).

Another health challenge is malnutrition. The elderly are the most uniformly undernourished segment of the population in less developed societies, particularly those in rural areas. There are a number of reasons for chronic malnutrition among the elderly, transportation difficulties in getting to shops, lack of knowledge about proper nutrition, lack of money to purchase a well-balanced diet, poor teeth or lack of dentures, which can greatly limit one's diet, lack of incentive to prepare an appetizing meal when one is living alone and inadequate cooking and storage facilities (Quadagno, 2002).

According to Moses (2012), the aged are faced with numerous health related problems such as dementia, depression, incontinence, arthritis, bedsores, vision and eye diseases, dry eye syndrome, cataracts, diabetes, and hearing loss.

Dementia

There are different types of dementia; memory loss and impaired cognitive function that affect the elderly (Moses, 2012). Memory tends to becomes less efficient with age. It might take longer to learn new things or remember familiar words or names. Everyone forgets things from time to time. Modest memory problems are a fairly common part of ageing, and sometimes medication side effects or underlying conditions contribute to memory loss. Memory changes, such as forgetting common words when speaking, getting lost in familiar neighbourhoods or being unable to follow directions, an evaluation with the doctor can be scheduled.

Depression

It is the commonest functional disorder among the aged (Moses, 2012). Frequent losses (for example, job, spouse, status, home) lead the elderly to acquire debased self-image and deflated self-esteem. Moreover, the elderly because of increasing lack of control over their life constantly feel a lack of self-efficacy. Depression can happen to anyone, at any age, no matter your background or your previous accomplishments in life. Feelings of sadness, grief and mourning are normal and appropriate depressive reactions to loss, feeling of guilt and hopelessness, withdrawal, psychomotor, retardation, decreased appetite, insomnia, weight loss. Unfortunately, since these changes are commonly thought of as “normal” in the elderly, depression in the aged is often not diagnosed or misdiagnosed. It has been

proposed that depression follows loses and stresses since older people are more likely to experience major loses, they are more likely to become depressed (Moses, 2012).

Depression is a common problem in older adults. The symptoms of depression affect every aspect of people's lives, including their energy, appetite, sleep, and interest in work, hobbies, and relationships. Unfortunately, all too many depressed seniors fail to recognize the symptoms of depression, or do not take the steps to get the help they need. According to Moses (2012), there are many reasons depression in older adults and the elderly is so often overlooked which include the following:

i. They may assume they have good reason to be down or that depression is just part of ageing.
ii. They may be isolated which in itself can lead to depression—with few around to notice their distress.
iii. They may not realize that their physical complaints are signs of depression.
iv. They may be reluctant to talk about their feelings or ask for help.

Physically, the elderly experience many stresses, crisis and losses, in addition to their need to cope with a devalued status (Moses, 2012). For example, they unlike other segments of population, need more intervention even in minor physical matters, which may otherwise rise to a major concern.

The changes that often come in later life such as retirement, the death of loved ones, increased isolation, health problems and many more can lead to depression (Moses, 2012). Depression prevents people from enjoying life like they used to. But its effects go far beyond mood. It also impacts our energy, sleep, appetite, and physical health. However, depression is not an inevitable part of ageing, and there are

many steps one can take to overcome the symptoms, no matter the challenges they face. Depression is a serious medical illness. It is more than just feeling "down in the dumps" or "blue" for a few days. It can be mild or so major that it is disabling and it can also be hard to recognize.

Incontinence

Incontinence, or loss of bladder control, can happen for a number of reasons. Whether it is temporary or chronic, it is unpleasant. It also can lead to emotional distress. The elderly will find it difficult to retain urine in the bladder so they urinate without control (Moses, 2012). Loss of bladder control is common with ageing. Medical conditions, such as diabetes, might contribute to incontinence as can menopause, for women, and an enlarged prostate, for men.

Arthritis

Arthritis is a painful condition that can strike the spine, neck, back, shoulder, hands and wrists, hip, knee, ankle, and feet. It can be immobilizing, and it comes in many forms (Moses, 2012).

Bedsores

Bedsores also known as pressure ulcers are skin ulcers that develop from pressure when people lie in bed or sit in a chair for long periods of time. Bedsores are a fairly common problem in elderly people who have difficulty moving on their own (Moses, 2012). People with diabetes are more prone to bedsores because of their poor circulation and decreased feeling in their skin. Frequent rotation or re-positioning helps to prevent bedsores.

Vision and Eye Diseases

According to Moses (2012), macular degeneration, cataracts, glaucoma, presbyopia, and retinal disorders are just some eye diseases that can reduce an elderly's ability to see well.

Dry Eye Syndrome

When people get older, their tear ducts do not work as well as when they were younger (Moses, 2012). Their eyes lose moisture and can become dry and distressing. They can itch, burn and go red. In most cases, the drawback can be resolved by using a humidifier, having prearranged eye drops and, in severe conditions, surgery.

Cataracts and Glaucoma

Most important improvements in health care have made the drawback of cataracts much more treatable. Once people get cataracts, the lens of their eyes becomes cloudy and it is difficult to see, particularly at night with the bright car lights. Now with out-patient day surgery, most cataract patients have greatly enhanced eyesight. Glaucoma is an eye problem that is often genetic and worsens with age (Moses, 2012). By this condition, the fluid pressure goes up inside the eye. This pressure can damage the optic nerve that sends messages to the brain. It can also cause blindness.

Diabetes

Having high blood glucose levels is the hallmark of diabetes, a group of diseases that affects the body's ability to produce or use insulin correctly among the elderly (Moses, 2012).

Hearing Loss and other Health Challenges

About a third of older people between the ages of 65 and 74 have hearing problems. That statistic increases with age (Moses, 2012). Osteoporosis is a condition that causes bones to break more easily and take longer to heal. As a result, even minor falls can land the aged in the hospital. Lung diseases can diminish an elderly person's ability to breathe well. While many types of lung problems can be treated or prevented, they can be serious, with major complications. Constipation is more common in older adults. Many factors can contribute to constipation, including a low-fibre diet, not drinking enough fluids and lack of exercise. Medications such as diuretics and iron supplements, and certain medical conditions, such as diabetes and irritable bowel syndrome, also might contribute to constipation.

2.5 Support Systems for the Elderly

The amount and type of elderly care varies from culture to culture. For example, in Asia the responsibility for elderly care lies firmly on the family (Yap et al., 2005). This is different from the approach in most Western countries, where the elderly is considered independent and are expected to tend to their own care. These differences are based on cultural attitudes toward ageing.

The support systems that are available for the care and welfare of the elderly include the family (informal) and state as well as other institutional support systems. The informal support involves the kind of social support provided by family members, friends, neighbours, and other significant others. Institutional support involves those support and welfare schemes provided by state institutions, religious organisations and non-governmental organisations (NGOs).

Hutchison (2011) was of the view that the type of support and assistance that the elderly persons receive can be categorized as either formal/state or informal resources. Formal or state resources are those provided by formal service providers and these resources have eligibility requirements that a person has to meet in order to qualify. Some formal resources are free, but others are provided on a fee-for-service basis, meaning that anyone who is able to pay can request the service. Informal resources are those provided through families, friends, neighbours and churches. Elderly persons receive a considerable amount of support through these informal support networks (Wacker & Roberto, 2008; Hutchison, 2011).

According to Suitor et al. (1995), family support is often viewed in juxtaposition to state support, within a general division between informal and formal support systems. The relationship between the two is shaped by how much of each is available and/or desirable in a particular context.

Field, Walter and Orrell (2002) posited that social support is one of the most important factors in predicting the physical health and well-being of everyone, ranging from childhood through older adults. The absence of social support shows some disadvantages among the impacted individuals. In most cases, it can predict the deterioration of physical and mental health among the victims. The social support given is also a determining factor in successfully overcoming life stress. The presence of social support significantly predicts the individual's ability to cope with stress.

2.5.1 Family Support System

In the opinion of Hutchison (2011), the core societal institution is the family, consisting of positions such as spouse, parent, child, and stepmother and of roles that

prescribe how individuals who hold those positions should act. The structure of a person's family affects the structure of that person's social support systems. The family as the basic social unit provides major support to the elderly. When even state support is lacking but there are strong extended family bonds, elderly neglect is likely to be minimal (Hutchison, 2011). However, in the situation where there is compression of genealogical ties in family behaviour, strengthening of marital bonds at the expense of the family, crave for small-family size and failure to reciprocate responsibilities, the situation of the elderly may be terrible. Older people today are part of a revolution.

The family is the most important provider of informal resources for many elderly persons. According to Hutchison (2011), about 80% to 90% of care provided to elderly persons living in communities is provided by the family members. Family members are able to provide better emotional and social support than other providers of services. Family members know the person better and are more available for around-the clock support. Different family members tend to provide different types of assistance. Daughters tend to provide most of the care-giving and are more involved in housekeeping and household chores. Sons provide assistance with household repairs and financial matters (Wacker & Roberto, 2008 cited in Hutchison, 2011).

However, the family should not be considered a uniformly available resource or support because not all family networks are functional and able to provide needed support. Even when family members are involved in the elderly person's life, they may place additional demands on the elderly person instead of relieving the burden. The increased pressure of women in the labour market puts them in a particularly difficult position trying to balance the demands of raising children, taking care of their

parents and being part of the workforce. Again, the size of the family network available to support elderly persons is decreasing because of the decreasing average number of children in a family (Hutchison, 2011). The second informal resources are friends and neighbours, who often provide a significant amount of care and assistance. Although they may be less inclined than family members would be to provide personal care, friends and neighbours often offer other forms of assistance, which may include running errands or performing household chores (Hutchison, 2011). Religious bodies in communities also provide social and emotional support through group activities and community events to the elderly.

At any age, the family provides the individual the emotional, social, and economic support (Banga, 1992). The ability of aged persons to cope with the changes in health, income, and social activities, depends to a great extent on the support the person gets from his/ her family members. This support, it may be said, is more culturally based rather than development dependent. For instance, in Ghana, the cultural values emphasize that the elderly members of the family be treated with honour and respect. Older persons in so many other ways help to foster national and community cohesion (Banga, 1992). They also often serve as reliable custodians of tradition and custom. It is important therefore to develop interventions to ensure change in attitudes, policies and practices at all levels in all sectors to address concerns of ageing and promote the positive contribution of older persons in our society.

Furthermore, the rapid increase in the ageing phenomenon is global which affects both developing and developed countries alike (Banga, 1992). It is also worth noting that older persons are not a homogeneous group and therefore planning for

their needs require country specific action plans and programmes. This is because UN resolutions and other international declarations only provide the framework for such country specific programming.

According to Aboderin (2003), material family support for older people in Ghana, as in other African countries, has declined in recent decades, exposing increasing numbers especially of urban elderly to destitution and poverty. The nature and causes of this decline remain poorly understood, in particular the relative role of growing material constraints, as proposed by political economic perspectives, or weakening traditional values, as suggested by modernization perspectives. Due to pervasive poverty, it is hypothesized that there is an inverse relationship between modernization and family support for the elderly, resulting in a growing incidence of low levels of well-being among the elderly persons. In the traditional African society, children are expected to support their parents in old age because there is no universal social security system.

2.5.2 State and other Institutional Support Systems

As a result of lack of full knowledge of the implications of the changes taking place in the traditional family, it is still assumed in most of these settings that the family will continue to provide the context within which the needs of the older population could be met. In Ghana, most of the aged depend on their families and relatives for assistance and support, but if an aged has no relative to assist of him or her, he or she is left to suffer alone and sometimes starved to death. For this reason, the then Minister of Health, Joseph Yiele Chireh emphasized the need for Ghana to have a policy that will promote active ageing and also make use of existing structures to cater for the aged. He said, in a situation where Ghana's joint family system and

family values are gradually eroding and taking away the traditional safety nets for the elderly, we need to find appropriate measures that will provide the elderly with some support and care (Yeboah, 2011).

According to the 2010 Population and Housing Census, persons aged 65 years and above and considered aged, constitute 5 per cent of Ghana's population. (Ghana National Development Planning Commission, 2005). As part of his address, the Health Minister indicated that from a health perspective, Ghana needs to organize health services with emphasis on addressing active ageing and the life course. In short, there should be a policy on geriatric care in Ghana; a policy that will bring on board all other services that will promote active ageing and make use of existing structures to cater for people in old age in this country. Apart from the issue of income security, the Minister said perhaps health security represented one of the basic pre-requisites of an enjoyable life for elderly people, adding that health in old age depends on people's lifestyle and behaviour during their life-span. If the immediate family members or relatives are not available to help the aged, outside help should be immediately given; this can be nurses, counsellors, or social workers.

In the process of drafting the National Policy on Ageing, HelpAge Ghana provided research material on ageing issues, worked with lead consultants to identify key policy issues, participated in working group meetings and workshops. HelpAge Ghana won a promise of support for the ageing policy which the Ministry of Employment and Social Welfare, the ministry responsible for developing the National Ageing Policy at a meeting with a delegation of older people who participated in the discussion on the ageing policy on 1st October 2010 as part of the Age Demands Action campaign (HelpAge International, 2011).

The National Ageing Policy outlines some of the challenges of the elderly and the growing proportion of older people in the country. According to the policy the problem of poverty among older persons would be difficult to solve unless it is addressed in relation to the adequacy of income security and provision of services to improve active ageing and well-being of older persons (HelpAge International, 2011).

National Ageing Policy Implementation Action Plan contains commitments to expand special poverty reduction programmes for older persons, to increase the social welfare budget for older persons to be announced in the 2012/2013 budget and to increase specialized health service delivery for older persons, also in the 2012 budget (HelpAge International, 2011).

The ageing process exposes individuals to increasing risk of illness and disability. As Ghana is a developing country, lifetime exposure to health problems means that most Ghanaians may enter old age already in chronic ill-health. Personal health consistently ranks alongside material security as a priority concern for the aged. Indeed, physical health is for many rural elderly persons their single most important asset, bound up with their ability to work on the farms, to function independently, and to maintain a reasonable standard of living.

It should be noted that even countries with a high level of economic and social development would find it difficult adjusting to a rapidly ageing population. Then for countries still struggling with the problems of underdevelopment, where unfortunately most of these African countries are currently located, the challenges will be undeniably formidable. The government of Ghana, and indeed African governments, should be aware of the plight of the elderly before the situation gets out of hand because there is almost no social security benefits for most of the aged in much of

Africa, majority of whom are illiterates and who therefore could not enjoy the benefits of formal employment and the concomitant pensions. Because of these foregoing reasons, it is important that our developing country governments are sufficiently sensitized. In particular, the government of Ghana should know about the consequences and implications of the phenomenon of population ageing in order to plan for the "rainy day." One way of doing this is to always highlight the challenges precipitated by population ageing in the country, detailing research gaps and proffering plausible solutions.

The National Policy on Ageing was prepared in collaboration with the Centre for Social Policy Studies (CSPS) of the University of Ghana in February 2002 and submitted to Cabinet on 28th March, 2003. The draft policy sought to recognize the rights of older persons, respond to challenges that affect them and promote the active participation of the aged in mainstream society for national development. Additionally, ageing is an inevitable natural process, such that with an improvement in life expectancy as a result of better health facilities, improvement in quality of life, and control over many killer diseases, populations all over the world bearing the absence of accidents shall age. It is therefore imperative that governments and policy makers take adequate steps to provide for the phenomena in a more formalized and systematic manner.

Older persons are also recognized as part of the national population and in fact the end of the life cycle and therefore should continue to have their rights respected and needs met for by all other members of society through policies and programmes. At best there should be specific laws and policies to direct their development and continuous existence. It is mandatory for all UN member states which Ghana is a

reputable member to develop national plans and strategies that aim at adding quality life to the years of older persons in conformity with the millennium declaration of a society for all ages and through that ensure that specific budgetary provisions and other sources of funds are made to facilitate the implementation of programmes for older persons.

Ghana has developed a National Social Protection Strategy (NSPS) to enhance the capacity of poor and vulnerable persons by assisting them to manage socio-economic risks, such as unemployment, sickness, disability and old age (Ministry of Employment and Social Welfare, 2010). These interventions are meant to increase the livelihoods of target groups by reducing the impact of various risks and shocks that adversely affect income levels and opportunities to acquire sustainable basic needs. Generally, in Ghana, the primary causes of vulnerability and extreme poverty are caused by such factors as natural/man-made disasters, health shocks, life-cycle shocks and exclusion and denial of rights. The social protection strategy draws attention to the need to take a collaborative and innovative approach to provide social empowerment initiatives to improve the livelihoods of poverty stricken Ghanaians including older persons (Ministry of Employment and Social Welfare, 2010). The strategy further suggests ways of ensuring that social protection plays a key role in improving health and education outcomes and provides strategies to prevent income loss, old age insecurity pension) and skills development both for the formal and informal sectors.

2.5.3 Government's Support for the Elderly

According to the Ghana Population and Housing Census (2010), persons aged 65 years and above are considered aged. They constitute six per cent of Ghana's population of more than 24 million. As a developing country Ghana has to give serious attention to the issues relating to the aged population. In the Ghanaian Society, the cultural values and the traditional practices emphasize that the elderly members of the family be treated with dignity and respect. The families of the aged persons are expected to ensure the needed care and support for the aged (Ministry of Employment and Social Welfare, 2010). However, recent changes in the size and structure of families have caused the re-arrangement of the roles and functions of the members in the families.

The Government of Ghana has taken up the responsibility to take care of the aged and have started certain schemes to provide care and support for the aged (Ministry of Employment and Social Welfare, 2010). Also, there are some non-governmental organizations (NGOs) which have undertaken the work of taking care of the aged. However, it is still the family that plays the most important role in Ghana in this respect.

In India for instance, Bowling (1997) specifies the rights of parents without any means for maintenance to be supported by their children having sufficient means. If any person refuses or neglects to maintain their parents, a magistrate may order such a person to make a monthly allowance for the maintenance of his/ her mother or father at a monthly rate not exceeding Rs.500 (Ochberg, Zarcone, & Hamburg, 1972).

Government Pension scheme in Ghana has become the most sought after income security scheme (Ministry of Employment and Social Welfare, 2010). The policy seeks to ensure that the settlement of Pension, Provident fund, Gratuity, and other retirement benefits is made promptly. It is also proposed to set up a Welfare fund for the old age persons. Regarding health care for the elderly, the goal of the policy is to provide good affordable health services. In this process it envisages to have the cooperative efforts of the public health services and of the private health services and of the private medical care. Development of health insurance is also being given high priority. Mobile health services, special camps, and ambulance services are thought of, for making the health care facilities to reach the elderly.

For solving the problem of providing housing for the elderly, group housing is proposed, which will have common service facilities for meals, laundry, common room and rest rooms. These should have easy access to community services, medicare, parks, recreation and cultural centres. Government proposes to encourage construction and maintenance of old age homes (Ministry of Employment and Social Welfare, 2010). However, family is recognized as the main provider of old age support not only in the area of housing but also in other areas which are crucial to old age persons.

The pension policy also proposes to develop educational and informational material relevant to the lives of older people such as the creative use of leisure; appreciation of art; culture and social heritage; skills in community work and welfare activities (Ministry of Employment and Social Welfare, 2010). Further, it will provide information about the process of aging and the changing roles, responsibilities and relationships at different stages of the life cycle. Elderly people could live longer if

they are well catered for, respected and made to feel a sense of belonging, a report from the Labour Research and Policy Institute of the Trades Union Congress (TUC) on Elderly Care Arrangements in Ghana indicated that the government had instituted measures such as the Livelihood Empowerment Against Poverty (LEAP) to support the aged.

At a forum organised by the TUC, in collaboration with the Danish Union of Public Workers in Accra on 8th May, 2013, the institute noted with concern that care and support for older people in Ghana, which had hitherto been the responsibility of the family, now appeared to have been taken over by paid domestic workers (Ministry of Employment and Social Welfare, 2010). The institute raised the concern that out of the over 1.5 million elderly people, representing six per cent of Ghana's population, only 100,000 of them were covered by a social welfare scheme that entitled them to receive some sort of allowance such as pension.

2.5.4 Support System of Non-Governmental Organisations for the Elderly

Government alone cannot take care of all the needs of the older population. The private sector consisting of the Voluntary Agencies and the family must have to play an important role in this regard (Kludze, 1988). The Non-Governmental Organizations (NGO) sector constitutes a very important institutional mechanism to provide user friendly, affordable services to take care of the elderly persons. However, this sector in India is playing only a minor role catering for rather small segment of the old age population, which is capable of paying for the services rendered. NGOs run Old Age Homes and Day Care Centres where old age persons are admitted for a specified charge per month.

The care the elderly receives also depends on the availability of institutional support such as hospitals, day care centres, and policies by the government or the state (Kludze, 1988). When these support systems are available, the elderly will have their needs met. However, when government institutional support is absent, the elderly are likely to be neglected. In addition, caregivers also play a significant role in providing care to the elderly. The willingness of caregivers to offer support to the elderly will ensure that their needs will be catered for (Kludze, 1988). However, in the situation where caregivers become frustrated, stressed, overburdened with roles or lack training, the elderly suffers the consequences.

The features and scope of statutory programmes in Africa vary in terms of the programmes provided, the basis of eligibility, funding and administration. In Ghana, social security appears to be the primary statutory programme provided for the elderly. This income security seems to be diminishing with age as a result of the absence of adequate pension schemes and social security benefits for the elderly in the informal sector (Kludze, 1988). Overall, the lack of universal coverage is a grim manifestation of inequality and marginalization. Persons who are not part of the formal sector are not included in the only surviving but weak pension scheme (Kludze, 1988). This means that people in the rural areas who form the majority of the country's population and are engaged in the informal sector have no benefits to rely on when they retire from work. The situation suggests that in spite of the advent of the modern welfare state in Ghana, non-statutory welfare programmes provided by the family continue to be the only source of security to a sizeable percentage of the elderly population (Darkwa, 1997).

Although the pension programme continues to be the main source of security for the elderly in Ghana, there are several limitations that work to undermine the effectiveness or otherwise of the programme. These include low payment and lack of adequate coverage. The social security scheme covers only a small percentage of the Ghanaian workers attached to the formal sector (Nukunya, 1992; Asiedu et al., 2004). Gender inequalities in the Ghanaian context add up to make the situation problematic. Since most Ghanaian women are attached to the informal sector, the majority are less likely to qualify for any form of statutory scheme as the social security and National Insurance Trust. Given the limitation of the current National Health Insurance Scheme, it will be important to have a general scheme that meet the needs and aspirations of our senior citizens and promote their quality of life.

The implementation of social insurance programmes in the formal sector of the economy dates back to the era of colonial rule. The colonial government provided coverage to individuals in the formal sector while individuals from the non-wage sector were often excluded. Since then studies have revealed that apart from operations of private insurance companies, there has not been any marked changes in the nature, structure and operations of the SSNIT pension scheme, the survival national social security for the elderly (Darkwa, 1997). There have been changes in the traditional family system due to urbanization and modernization together with several other factors. As a result, older people are no longer able to rely on the family for support, especially in meeting their health needs. The situation often demands the use of social welfare programmes to play the vital role of cushioning those who are most vulnerable especially the elderly. Good health is vital for economic growth and the development of societies. Older people's capacity to earn a living and participate

in national development, and community and family life, to a large extent depends on their state of health. In view of this, there is the need to strengthen the various social networks that help or assist the elderly to access health care. Though older persons are fully entitled to have access to preventive and curative care, including rehabilitation and sexual health care, they are often denied them as noted by the United Nations [UN](2002).

Governments over the years have sought to promote the health needs of the people of Ghana. Thus, successive governments in partnership with both local and international bodies have put in place policies, programmes and other measures to ensure the health needs of the people but unfortunately citizens of Ghana despite these efforts are still struggling to meet their health needs especially the ageing or elderly (Atim, Grey & Apoya, 2001). Due to these failures in the government and family systems in the care and protection of the elderly, the elderly in the country find ways to fend for themselves during their old age and retirement.

Sometimes in the formal sector, some of the elderly going on retirement may have saving with SSNIT and will have to fall on it for survival, together with this some also from the public sector receive pension pay monthly but these monies are always insignificant especially in Ghana (Atim et al., 2001). Again, others who were once in the security services resort to becoming security guards in private homes or public institutions so they can earn a living to care for themselves.

If the elderly in organized occupations are faced with such a challenge, then what shall those in the informal sector and rural areas do? Survival becomes more serious for the elderly who were once farmers, artisans, petty traders, among others during retirement (Atim et al., 2001). Unfortunately, there is no or little organized

system for providing for the elderly in Ghana. Most of these elderly who become so weak due to the nature of their work may still have to do a similar work for survival even in their old age; some may become domestic house-helps doing all kinds of work, which their strength may not allow them (Atim et al., 2001). In the case of security guards, it is even more risky in that they are expected to protect property, which needs physical strength to combat armed robbers or thieves.

In some cases, the elderly who are blessed with well-to-do children or families who can afford to employ the services of other caregivers or caretakers to care for the needs of their elderly (Atim et al., 2001). These "nannies" either live with such families at their various homes or come to such homes in the morning and leave in the evening after they have finished with their day's work. Another survival strategy is the provision of recreational centres for the elderly by the society. This is a common practice among the Westerners but little is known about this in Ghana.

The only known old people's recreational centres in Ghana is at Osu and other private NGOs are working towards these strategies (Atim et al., 2001). Older people are sent to these homes by their families whilst they are off to work and come for them in the evenings. At this home, they meet other people and can interact with them. It must be noted that this survival strategy is not popular in Ghana because it comes with a cost as families would have to pay for these services; even if it exist it only applies to the urban elderly.

The case is different for the rural elderly; they, by virtue of ties and proximity, can afford to visit their friends when they feel lonely. For example, the rural elderly may visit their neighbours or other family members. Also in the rural areas, people are likely to show concern towards the elderly by way of providing them food, clothing

and shelter. However, this may not be the case in the urban centres where people live individual lives. Another survival strategy is where the children of the elderly take turns in caring for their parents or family members. What happens here is that, the older person is sent to be with a particular child for a while, and then at another time he/she moves to stay with another child. In most cases, they may be single old persons of such children, with either of their partners deceased, divorced or separated (Atim et al., 2001).

From the above it can be seen that the elderly do not have the same opportunity in living comfortable lives during their retirement. This makes the unfortunate ones especially those in the rural areas more vulnerable. Due to this, the state and NGOs take up the responsibility to assist people during their old age. For example, non-governmental organizations (NGOs) such as Akroma Elderly Life Foundation in Ghana could help alleviate the plight of these elderly men and women by giving some handouts or paying some medical bills.

There is unprecedented increase in the number of older persons globally, continentally and nationally. In fact, available statistics show similar trends in all regions and districts of Ghana. Worldwide population of older persons (65 years and above) is projected to increase from about 600 million in 2000 to almost 2.6 billion in 2050. Africa will not be spared from this rapid population growth of older persons. Ageing as a policy issue received international recognition at the first World Assembly on Ageing held in Vienna, Austria in 1982 to address ageing concerns and its implications for national development. Since then several ageing-related conferences have been held including the 1984 International Conference on Population and Development, The Second World Assembly on Ageing held in Madrid

in 2002, the Twenty Second Ordinary Session of the OAU Labour and Social Affairs Commission held in Windhoek, Namibia in 1999, the Expert Meeting hosted by the African Union (AU) in 2000, the 38th Session of Heads of State and Government held in Durban, South Africa in 2002. At these and other conferences Governments committed themselves to initiate policy interventions to address the challenges of older persons. It is also known that the incidence of disease and disability increase with advancement in age. It is therefore clear that the increasing numbers and proportion of older persons will mean that more special facilities and services in health, transport, housing and social services will be required to meet their specific needs most of which are usually expensive to obtain and maintain. While recognizing the seemingly negative impact of ageing on the economy it is also necessary to recognize that ageing has some positive influences on national development if properly planned. Apart from their increasing number, the quality of life of older persons should be of major concern to society. This is because the elderly require social and financial support for their well-being and survival.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter focuses on the general approach and specific techniques adopted to address the objectives for the research. The chapter specifically discusses the research design, population, sample and sampling procedure, research instrument used for the study, how the validity and reliability of instruments used for the research were determined, methods employed to collect data and data analysis procedure.

3.1Research Design

A descriptive survey research design was used for the study. The survey involves acquiring information about a group by asking questions, tabulating and describing answers (Saunders, Lewis, & Thornhill, 2009). The information is collected from a group of people in order to describe aspects or characteristics, (abilities, opinions, attitudes, beliefs, experiences or knowledge) of the population of which the group is part. Descriptive survey design dwells on a sample of the population rather than the whole to make generalizations. As observed by Hopkins (2002), descriptive surveys are appropriate for this type of research because they allow for the collection of data that may be used to assess current practices and conditions and to make intelligent plans to improve upon them. A common feature of a descriptive survey helps in assessing people's attitude or opinions toward a situation (Dornyei, 2007).

This design was chosen to enable the researcher describe the characteristics of the population by inferring from what was found out about the sample group. Additionally, it helped to answer the research questions guiding the study as well as the purpose of the study. It specifically, described the challenges faced by the elderly in Gomoa East District, the support systems available to them and how the elderly were managing the challenges.

3.2 Population of the Study

The population of a study is the group of interest to the researcher, the group to which the researcher would like to generalize the results of the study (Fraenkel & Wallen, 2000). They added that in educational research, a population is a group of persons who possess certain characteristics. The population of this study comprised all the elderly who were residents of the twenty-two (22) towns in the Gomoa East District aged 65 years or older, unless they were vegetative, stuporous, semi-comatose, suffering from dementia or other serious psychiatric diseases. Those people were excluded from the study because they could not give the needed information due to their health conditions. These conditions were detected by inquiring from family members and co-tenants. Again, the researcher chose this district because of proximity as she is a resident in the district. The research required the views of the elderly about the functionality of the support systems available to them. Statistics available, based on the 2010 Population and Housing Census revealed that the total number of the elderly in the district was 8, 093.

3.3 Sample and Sampling Procedure

A sample is a group in research study on which information is obtained (Saunders, Lewis, & Thornhill, 2009). There were twenty-two (22) towns in the district at the time of the study. Taking into consideration the fact that the socio-cultural and environmental climate in the district is the same in all the towns, simple random sampling technique was employed to select six (6) towns out of the twenty-two towns. Simple random sampling technique is defined as a sampling technique where every item or member in the population has an equal chance and likelihood of being selected in the sample (Gary, 1990). Here the selection depends entirely on luck or probability. Therefore every member or item has a chance of being selected. According to Lisa (2008) this technique does not require a random selection of participants based on any set of criteria instead, researchers can subjectively select participants at random. This means that the researcher can find his or her sample anywhere, for instance people in a mall, on the street, in the workplace or in any gathering.

It is a fair method of sampling and if applied appropriately, it helps to reduce biases (Gary, 1990). The lottery method was employed. It is a mechanical method in which the researcher gives each member of the population a number and then draws numbers from the 'box' randomly to choose samples (Johnson, 2012). So all the names of the twenty-two towns were written on pieces of paper and put in a container. A sample size of six was defined and randomly picked from the container.

After selecting the towns, convenience sampling technique was used to select the sample for the data collection. Convenience sampling technique is a non-probability sampling technique where subjects are selected because of the convenient

accessibility and proximity to the researcher. Non-probability sampling does not involve known nonzero probability of selection. Rather, subjective methods are used to decide which elements should be included in the sample (Sahler, 2007). There are no other criteria to the sampling method except that people are available and willing to participate. So upon entering each town, twenty respondents who were willing to participate were sampled in homes, on the street, at the market, clinic and any place within the town where elderly people were accessible.

From each town, twenty (20) elderly people were earmarked for data collection. Therefore, a total sample size of one hundred and twenty (120) elderly respondents, which represents about 3% (˜2.6%) of the elderly population in the district, was selected for the study. The choice of approximately 3% of the study participants is based on Dornyei's (2007) assertion that between 1% and 10% of a study population gives a magic sampling fraction. According to Dornyei (2007), there are no hard and fast rules in setting the optimal sample size; the final answer to the 'how large/small?' question should be the outcome of the researcher considering several broad guidelines. He gave rules of thumb which say that in the survey research, a range of between one percent and ten percent of the population represents an adequate sampling fraction. One hundred and twenty (120) elderly respondents were involved in the study it is an ideal sample size considering the research design used for the study. Again, a sample size of 120 elderly respondents was convenient to give a fair representation of the elderly in the District.

3.4 Instrumentation

The main instrument used to gather data for the study was questionnaire, which was self-designed by the researcher. The questionnaire was used to elicit information from the elderly aged 65 and beyond. The questionnaire consisted of an introductory part, bio-data information and sections A, B, C, and D. The introductory part contained information about the researcher and the aim of the study. It also assured respondents of ethical issues. The Bio-data section contained five items in section A. Section B helped to elicit information from the elderly about the different kinds of challenges they faced. Section C focussed on the support they received, D gathered information about how they coped with the process of ageing and E helped to elicit data on the impression the elderly had on the kind of treatment they received from family members.

Questionnaires were used because they provide a relatively cheap, quick and efficient way of obtaining large information from a large sample of people. They are useful for large populations when interviews would not be practical. They are economical. This means they can provide large amount of research data for relatively low costs. Again, the respondents provide information which can be easily converted into quantitative data and also the questions are standardized because all respondents are asked exactly the same questions in the same order. This means questionnaires can be replicated easily to check for reliability (McLeod, 2018).

3.5 Validity and Reliability of Instrument

Validity and reliability of the questionnaire were established first by submitting it to the research supervisor for comments. Appropriate changes were

made to modify and discard ambiguous and inappropriate items contained in the questionnaire. Also, the questionnaire was pilot tested using ten (10) elderly persons in Otabilkrom near Agona Swedru to determine its appropriateness and quality of information that would be gathered. The results showed that the elderly had similar challenges and coping mechanisms. The result from the pilot testing helped to reframe items which helped to elicit relevant and desired information from respondents.

In this study, internal consistency was tested on the questionnaire by means of Cronbach Alpha statistics with the help of Statistical Package for Social Sciences (SPSS) version 23. The analysis yielded a Cronbach's alpha coefficient (α) of 0.76 which is deemed as an acceptable measure of reliability because this is above the 0.70 the threshold value of acceptability as a measure of reliability as noted by Dörnyei and Taguchi (2010). This result implies that the instrument was reliable; hence it was used for the actual study.

3.6 Method of Data Collection

To meet the objectives of the study both primary and secondary data were used. Primary data were collected using set of questionnaire. This technique sought inter alia, to understand issues concerning the functionality of the support system of the elderly from the perspective of both the elderly and the officers. Secondary data were derived from published and unpublished documents and literature that were related to the elderly as well as the concepts cited by the respondents. The secondary data were collected from various sources including books, journals articles, internet material and other documents that were relevant to the study.

The questionnaire were self-administered to the sampled respondents. For respondents who could not read and write the English language, the researcher read and interpreted the questions to them using "Fante" as medium, and their responses were recorded on the questionnaire by the researcher. Completed set of questionnaire were collected on the same day to be coded for analysis. This was done to ensure high coverage, completion, and return rate. Collection of data for the research lasted over a period of four weeks, taking into consideration the fact that the researcher had to read and translate the questions from English to the local dialect for them to understand.

3.7 Analysis

The data gathered from the use of the questionnaire, were coded, graded and entered into the computer. Statistical Package for Social Sciences (SPSS) version 23, for windows was used for the analysis, to help generate frequency tables and for further explanations based on the research questions. The frequency tables were used to make summaries of respondents' responses and for drawing conclusions. With regards to data from the questionnaire that could not be entered into the SPSS version 16, they were analysed manually by making summaries of the views of respondents and supporting those views with appropriate meanings, (that spelt out the views of respondents).

3.8 Ethical Consideration

For ethical reasons, a letter of introduction from the Head of Department of Home Economics of the University of Education, Winneba, was obtained to introduce the researcher during the data collection, after establishing the necessary contacts with the respondents. The purpose of the study was explained to sampled respondents. This

letter was used to obtain permission from the elderly. Participants were assured of the necessary confidentiality. The administration of the questionnaire was done after consent was sought from the elderly. All information were kept confidential and utilised for research purposes only. The principal investigator kept all data.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter is divided into two major sections. The first section provides results on the demographic characteristics of the respondents and the results of data collected for the study. The second section discusses the findings of the study.

4.1. Results of the Study

This section presents the results of the study on the demographic characteristics of respondents, challenges faced by the respondents, the kinds of support they received, coping mechanisms adopted and their impressions about the care given to them by their families.

4.1.1 Demographic Characteristics of Respondents

Table 4.1 gives the description of respondents in terms of age distribution.

Table 4.1: Age Distribution of Respondents

Age range (in yrs)	Frequency	Percentage (%)
65 – 79	42	35
80 -84	38	32
85 -89	26	22
90 -94	10	8
95 – 99	4	3
100+	0	0
Total	**120**	**100**

Source: Field data (2017)

A total number of one hundred and twenty elderly persons were involved in the study. The results indicate that their ages ranged from 65 to 98 years old, with the mean age of 69 years. The dominant age group of the respondents ranged between 65 and 84 years representing 67%, whereas 95- 99 years group was the smallest group representing 2%.

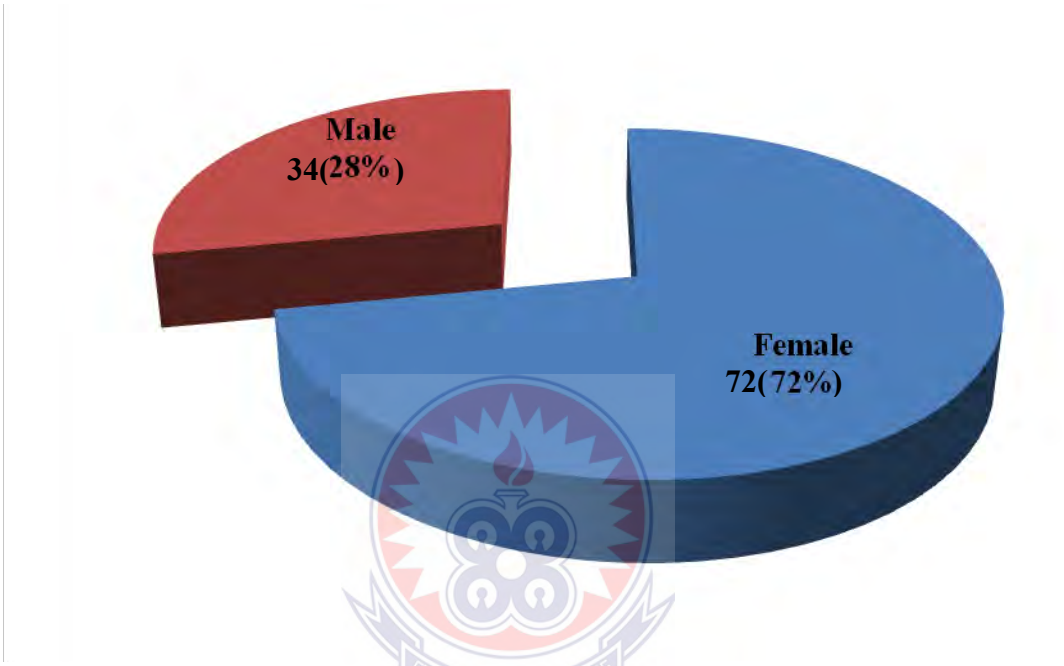

Figure 4.1: Gender of Respondents

Source: Field data (2017)

Figure 4.1 shows that 86 (72%) of the respondents were females whilst the remaining 34(28%) respondents were males.

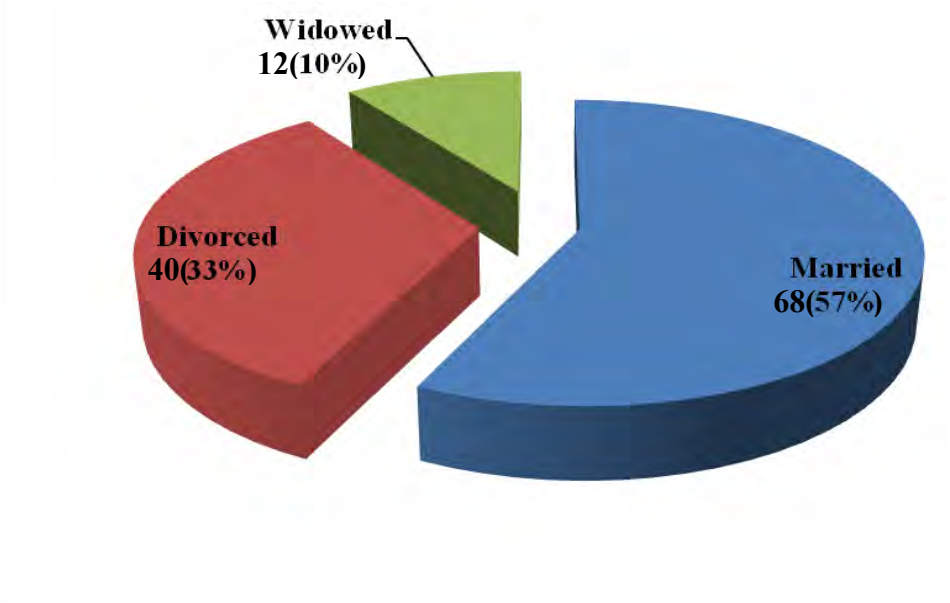

Figure 4.2 Marital Status of Respondents

Source: Field data (2017)

Figure 4.2 shows that 68 (57%) respondents were married, 12 (10%) were widowed and 40 (33%) were divorced.

Table 4.2: Number of children of Respondents

Number of children	Frequency	Percentage (%)
0 – 4	20	17
5 – 9	86	71
10 – 14	8	7
15+	6	5
Total	**120**	**100**

Source: Field data (2017)

Table 4.2 presents results on the number of children each respondent had. Out of the 120 respondents, 20 (17%) had 0-4 children, 86 (71%) had 5-9 children, 8 (7%) had 10-14 children and 6 (5%) had 15 or more than 15 children.

Table 4.3: Educational Background of Respondents

Educational Level	Frequency	Percentage (%)
No Formal Education	56	47
Elementary	30	25
Secondary	22	18
Tertiary	12	10
Total	**120**	**100**

Source: Field data (2017)

Table 4.3 shows that 56 (47%) of the respondents had no formal education, 30 (25%) had elementary education whilst 22 (18%) had secondary education, 12 (10%) respondents had tertiary education.

Table 4.4: Former Occupation **(N=120)**

Occupation	Multiple response	
	Frequency	Percentage (%)
Teaching	9	6
Farming	53	36
Fishing	19	13
Trading	42	28
Artisan	23	15
Nursing	2	1
Clergy	1	1
Total	**149**	**100**

Source: Field data (2017)

Table 4.4 gives multiple responses on the respondents' former occupation. This implies that some of them had engaged in more than one economic activity in the past. Nine (6%) said they were teachers, 19 (13%) responded that they were into fishing. Fifty three respondents representing 36% indicated that they were farming, 42 (28%) said they were traders whilst 23 (15%) said they were artisans, 2 (1%) were nurses and 1(1%) was a full-time Pastor.

4.1.2 Challenges faced by the elderly in GED

4.1.2 Age-related challenges of the respondents

Health Challenges

Table 4.5: Health Challenges of Respondents

	Multiple response	
Challenge	**Frequency**	**Percentage (%)**
Eye problems	57	22
Hearing impairment	32	12
Hypertension	51	19
Joint problems	49	19
Diabetes	28	11
Asthma	9	3
Cancer	0	0
Stroke	11	4
Hepatitis B	7	3
Incontinence	13	5
Parkinson's disease	7	3

Source: Field data (2017)

The respondents were asked to indicate their health challenges and Table 4.5 presents the various health challenges and the number of elderly persons who were facing a particular health challenge. The table gives multiple responses on the health challenges of the elderly. This means that some of them faced multiple health challenges. Out of the 120 respondents, 57 (22%) indicated that they were having problems with their sight, 32 (12%) of them had hearing impairment. Fifty one (51) of them representing 51 (19%) were hypertensive. Forty-nine (19%) said they were facing joint problems, and 28 (11%) were diabetic. Nine (3%) were asthmatic

patients, but none of the respondents was suffering from cancer. Eleven (4%) out of the 120 respondents had stroke, 7 (3%) had hepatitis B. The results show that 13 (5%) had urinary challenges or incontinence and 7 (3%) had Parkinson disease. In all, 104 out of the 120 respondents complained of more than one ailment. The remaining sixteen (16) respondents said they were suffering from only one kind of ailment.

Financial challenges

Table 4.6: Financial Challenges of Respondents

	Multiple response	
Challenge	**Frequency**	**Percentage (%)**
Inadequate feeding expenses	102	85
Inadequate medical care expenses	120	100
Housing (rent)	16	13
Inadequate clothing expenses	52	43
Family levies (*ebusua tow, nsawabɔdze*)	35	29
No financial challenge	23	19

Source: Field data (2017)

The respondents were asked to indicate their financial challenges with regard to money for living expenses. Table 4.6 presents multiple responses on the financial challenges of the elderly. The responses were (in ranking order): inadequate feeding expenses 102 (85%), inadequate medical expenses 120 (100%) and rent expenses 16 (13%). These were followed by inadequate expenses on clothing 52 (43%), and family levies 35 (29%). Out of the 120 respondents only 23 (19%) had no financial challenge because they had support from their families.

Social Challenges

Table 4.7: Living arrangements of respondents

Living arrangement	Multiple Response Frequency	Multiple Response Percentage (%)
Child(ren)	18	14
Spouse	18	14
Grandchildren	39	31
Co-tenants	22	18
Other extended family members	21	17
Live alone	6	5
Paid care-giver	2	1
Total	**126**	**100**

Source: Field data (2017)

Table 4.7 presents multiple responses on the kind of people the elderly lived with. The results show that 18 (14%) elderly persons lived with their children, 18 (14%) of them lived with their spouses and 39 (31%) lived with their grandchildren. Twenty-two, representing 18% lived with co-tenants, 21 (17%) lived with other extended family members. Six (5%) lived alone and 2 (1%) lived with paid care-givers.

This respondent's plight confirms the abandonment theory that explains the "neglect, isolation and loneliness" that older people above 65 years do experience. They feel abandoned because the younger generation goes out to work or start their own families therefore, they lack the bond and interaction they used to have.

Table 4.8: Frequency of visits by children of respondents

Response	Frequency	Percentage (%)
Daily	0	0
Once a week	22	18
Fortnightly	40	33
Once a month	26	22
Once in three months	8	7
Once in six months	4	3
Once in a year	12	10
More than a year	8	7
Total	**120**	**100**

Source: Field data (2017)

Table 4.8 gives responses on the frequency at which respondents had personal contacts with their children who had travelled out of town. None of the respondents had contacts with their children on a daily basis, 22 (18%) had contacts with their children once every week and 40 (33%) had contacts with their children once every two weeks. Twenty-six (22%) respondents had contacts with their children once in a month, 8 (7%) had contacts with their children once every three months, and 4(3%) said their children visited them once every six months. Twelve (10%) had contacts with their children once in a year and 8 (7%) also had contacts with their children more than a year. One of the respondents said that she was a widower and all her six children had travelled to the city to seek greener pastures. Four of them hardly came home, and the remaining two came every year to the Akwambo festival. When she once complained, one of them retorted in the negative.

Table 4.9: Number of close companions of respondents

Number of companions	Frequency	Percentage (%)
0	6	5
1-3	30	25
4 -6	40	34
7-9	34	28
10 or more	10	8
Total	**120**	**100**

Source: Field data (2017)

Table 4.9 gives responses on the number of significant others, including friends, neighbours or family members who respondents comfortably shared private matters with. Six (5%) respondents had nobody who they could comfortably discuss private matters, and 30 (25%) indicated they had 1-3 close companions. Forty (34%) respondents had 4-6 close companions, 34 (28%) had 7-9 close companions, and 10 (8%) had 10 or more of such people.

Table 4.10: Support from Family

Support	Multiple responses	
	Frequency	Percentage (%)
Financial	57	48
Cleaning the house	28	23
Cooking	18	15
Shopping/Marketing	25	21
Accompanying them to the hospital	5	4
Laundry work	28	23
Clothing items	49	41

Source: Field data (2017)

The results displayed in Table 4.1 are multiple responses on the kinds of family support available for the elderly in the Gomoa East District. Fifty-seven (27%) respondents received financial support from their families, 28 (13%) elderly were assisted in cleaning their houses and 18 (9%) of them were assisted in cooking. Twenty-five (12%) elderly were supported in shopping and marketing and only 5 (2%) respondents were accompanied to the hospital whenever they got sick or had to go for check-ups. Again, 28 (13%) elderly received laundry assistance and 49 (23%) were given clothing items by their family members.

Table 4.11: Support from the District Assembly

Support	Frequency	Percentage (%)
Financial	0	0
Recreational	0	0
Educational/Counselling	0	0
Clothing Items	0	0
Registration of NHIS	59	49

Source: Field data (2017)

Table 4.11 presents results on the kinds of support received by the elderly from the Gomoa East District Assembly. For national health insurance scheme 59 respondents benefited. There was no other support for the elderly.

Table 4.12: Support from Religious Bodies

Support	Frequency	Percentage (%)
Financial	30	25
Visitation	81	67
Laundry work	0	0
Cleaning the House	2	2
Counselling	0	0
Recreational	0	0
Clothing Items	0	0
Food Items	7	6

Source: Field data (2017)

Table 4.12 indicates the various kinds of support given to the elderly by religious bodies in the Gomoa East District. Thirty (25%) respondents received financial support from their religious denominations, whereas 81 (67%) elderly were visited by their religious affiliations. With regards to cleaning the house, 2 (2%) elderly stated that church members occasionally came to clean their house, and 7(6%) received food items from their religious organizations. No one received supports like counselling, recreational programmes or clothing items from their religious organizations.

As regards the kinds of supports they received from their religious affiliation, some respondents had these to say: one respondent explained that there was a welfare scheme but the benefits covered death, marriage, birth and surgery. It is his family that will benefit when he dies because she would not marry or give birth again so the only support from her church is the encouraging words from the pulpit that give her hope.

Another respondent said that she was one of the infirm members of her church. The church visited her monthly and during such visits they prayed for her, shared the word of God, administered the Holy Communion and gave out some amount of money. Every Christmas she received some food items and money from the church.

4.1.4 Coping Strategies adopted by the Respondents

Table 4.13: Coping Strategies used by the Elderly to deal with Financial Challenges

Strategy	Frequency	Percentage (%)
Begging	5	4
Sale of personal property	12	10
Petty Trading	15	13
Support from Family	44	36
Support from religious organization	15	13
Farming	16	13
Baby Sitting	3	3
Nothing at all	10	8
Total	**120**	**100**

Source: Field data (2017)

The results presented in Table 4.13 show the various coping strategies adopted by the elderly to meet financial challenges. The results show that 5 (4%) elderly adopted begging for alms, 12 (10%) sold their personal property, 15 (13%) engaged in petty trading and 44 (36%) were being supported by their family members. Fifteen (13%) respondents received regular remittances from their religious affiliation, 16 (13%) engaged in farming, 3 (3%) were baby sitters, and 10 (8%) could not support themselves financially.

Table 4.14: Coping Strategies used by the Elderly to deal with Social Challenges

Strategy	Frequency (Multiple Responses)	Percentage (%)
Attending religious functions	76	63
Attending Funerals	98	82
Watching TV	24	20
Sitting by the roadside	12	10
Telling Folktale	14	12

Source: Field data (2017)

The results in Table 4.14 show the various coping strategies adopted by the elderly to meet their social challenges. Seventy six (63%) of the elderly coped by attending religious functions, 98 (82%) coped by attending funerals, 24 (20%) coped with loneliness by watching TV, 12 (10%) sat by the roadside to break boredom, and 14 (12%) told folktales.

Table 4.15: Coping Strategies used by the Elderly to deal with Health Challenges

Strategy	Multiple response	
	Frequency	Percentage
Visiting the hospital	18	9
Visiting the community clinic	37	19
Buying over-the-counter medicine	42	22
Herbal treatment	90	75
Spiritual healing	37	19

Source: Field data (2017)

Table 4.15 presents multiple responses on the coping strategies adopted by the elderly to meet their health challenges. According to the results, 18 (9%) respondents coped by visiting the hospital, 37 (19%) coped by attending the clinic, and 42 (22%) coped by buying over-the-counter medicine. Ninety (75%) respondents used herbal treatment to treat some kinds of diseases. Thirty-seven (19%) elderly resorted to spiritual measures to cope with health challenges.

Table 4.16 Impressions of Respondents about the kind of Support received from their families.

Respondents' impression	**Frequency**			
	Yes	**%**	**No**	**%**
My family members see me as a burden	30	25	90	75
I feel loved in my family	82	68	38	32
I'm well respected	94	78	26	22
I'm satisfied with the kind of care and support given by family	74	62	46	38

Source: Field data (2017)

Table 4.16 depicts responses on respondents' impression about how they were treated by their family members. Thirty (25%) respondents said their family members saw them as a burden whilst 90 (75%) respondents were regarded as assets to their families. Twenty-six (22%) respondents intimated that they were not respected in their families whilst 94 (78%) of them felt well respected. When asked about their general impression about the kind of care and support given by their family, 46 (38%) declared that they were not satisfied but 74 (62%) of them said they were satisfied. On the other hand, 82 (68%) respondents indicated that they felt loved in their families, but 38 (32%) gave opposing views.

4.2 Discussion of Findings

This section deals with the discussion of findings derived from the presentation of data collected. The discussion is based on the demographic characteristics of respondents, their challenges, how they coped with those challenges. The kind of support the respondents received and their impression about how they were treated by their family members.

4.2.1 Demographic Characteristics of Respondents

The demographic characteristics of the study touched on respondents' ages, gender, marital status, educational background, number of children and former education.

Age of Respondents

The results on the age distribution of respondents in Table 4.1 showed that 42(35%) of the total number of respondents fall within 65-79 years age bracket, followed by 19 (32%) in the bracket of 80-84. Those in the range of 85-89 years were 13 (22%) whilst 5 (8%) were aged 90-94 years, only 2 (3%) were aged between 95-99 years. None of the respondents was 100 years or more (Table 4.1). The results show that respondents were relatively not too old.

Gender of Respondents

The result on the gender of respondents showed that a greater percentage of them (72%) were females as it can be found on Figure 1. Only 28% of them were males. This is similar to the age structure of the country's population pyramid where females 65 years or more are more than their male counterparts (Ghana Statistical

Service, 2010). According to the 2010 Population and Housing Census report the enumerated population in the census 2010 was 24,658,823 made up of 12,024,845 (48.8%) and 12, 633,978 females (51.2%), giving an overall sex ratio of 95.2/100. The situation is also not different from life expectancy for females (58 years) and males (57 years) which give an indication that, males die relatively earlier than females (Ghana Statistical Service, 2010).

Marital Status of Respondents

The results on the marital status of respondents in Figure 2 shows that majority of them 68 (57%) were married, 40 (33%) of them were divorced and 12 (10%) being widowed. For the simple reason that people usually die at old age, it is expected that there would be an increase in the percentage of widows among the aged than any other age groups. Widowhood among the Africans is a very common experience as it is in other societies as well. Thus, the fact that all the respondents were sixty-five years and older gives the indication that it is likely that the number of the widowed will be higher yet there was a decrease. The decrease in the proportion of the elderly population who are widowed could be attributed to the fact that there is an increase in life expectancies, meaning more people enter old age with their marriages still intact.

Educational Background of respondents

The results on the educational background of respondents (Table 4.3) reveal that a greater percentage 56 (47%) was disadvantaged in terms of formal education whilst only 12 (10%) had tertiary education. Thirty (25%) respondents had elementary education whilst 22 (18%) had secondary education. Lack of education was found to

have negative impact on their ability to provide adequate care for themselves and those co-residing with them. Studies have shown that there is a link between the level of education and the intensity of age-related challenges (Rosow, 1967). As pointed out by Dowd (1975) education is a basic socio-economic variable and to a great extent determines an individual's social status. For example, it influences the kind of occupation an individual will be engaged in and determines life after retirement. It is now widely recognized that health outcomes are deeply influenced by one's level of education and income as well as place-based characteristics of the physical and social environment in which people live. The elderly with higher educational levels are well informed about ageing and its processes and are likely to adjust economically, socially and also make informed choices about challenges associated with ageing. Therefore, it is possible that the educated ones among them may not attribute certain unpleasant changes in the body to the activities of evil spirits, again they may be the ones on the government's pay roll for pension benefits to ease them from financial constraints.

Olsson and Ingvad (2001) opine that education is linked to our life experiences in various ways including health outcomes. Among the most obvious explanations for the association between education and health is that education itself produces benefits that later predispose the recipient to better health outcomes.

Cognitive impairment and dementia occur commonly in the elderly population and increases in incidence within those older than 65 years. Several studies have analysed risk factors for development of dementia, specifically Alzheimer's disease. Beyond health risk factors such as diabetes, hypertension and hyperlipidemia, several

factors such as economic background, level of education, physical activity and leisure activities have a link to the risk of cognitive decline (Moses, 2012).

4.2.2 Research Question 1

What are the challenges faced by the elderly in GED?

The first research question was intended to find out the various challenges faced by the elderly in Gomoa East District. The findings of this study reveal that 104 (87%) elderly suffered multiple health challenges. It unfolds that 57 (22%) of the respondents were suffering from eye problems while 32 (12%) complained about hearing impairment. The study revealed that 51 (19%) were hypertensive, 49 (19%) said they were suffering from joint problems, whereas 28 (11%) were diabetic as 7 (3%) were asthmatic. None of the respondents had cancer, 11 (4%) were suffering from stroke and a small number of the elderly 7 (3%) were living with hepatitis B. T

Thirteen (5%) respondents were struggling with incontinence and 7 (3%) had Parkinson's disease. Research shows that even in developed countries the elderly face multiple health challenges. Sixty-two percent (62%) of Americans who are 65 years and above suffer from multiple health conditions. Studies have shown that the most prevalent individual conditions among the over 65 population include: arthritis (57%), hypertension (55%), pulmonary disease (38%), diabetes (17%), cancer (17%), osteoporosis (16%) (Sahler, 2007).

With regards to the financial status of the elderly the study shows that out of the 120 respondents only 3 indicated that they had no financial challenge. Agarwal and Busse (2010) posited that one source of serious chronic stress is as a result of lack of an adequate income among the elderly. Agarwal and Busse are right because at that

time of their lives most elderly persons will be out of well-paid jobs, also the strength to work as before will not be available. This will definitely affect their finances negatively.

Again, the study revealed that 18 (14%) respondents lived with their children (Table 4.7). Those who lived with their spouses were 18 (14%) and 38 (31%) also lived with their grandchildren. There were others who lived with co-tenants 22 (18%) and those who lived with extended family members 21 (17%). A small percentage 2 (1%) of the respondents lived with paid care-givers and 6 (5%) lived alone. Bartram and Roe (2005) assert that the most common living arrangement for the elderly in nearly all developing nations is co-residence with children or grandchildren. In Africa and Asia, roughly 75% of the elderly co-reside with children or grandchildren. Living with their relatives, co-tenants or paid care-givers will help the elderly with their social interaction more than those who lived alone. Elderly people who live alone are likely to suffer from loneliness as compared to their counterparts who co-reside with other people. Loneliness can also lead to depression which is a serious health condition.

Results on the frequency of visits by the children (those who had travelled) of the respondents as presented in Table 4.8 show that none of the respondents had a daily visit by their children. Twenty two (18%) of them were visited weekly, 26 (22%) were visited once a month whereas 12 (10%) visited yearly. Forty (33%) of the respondents were visited fortnightly, minority of them 4 (3%) once every six months, 8 (7%) were visited once every three months and another 8 (7%) were also visited more than a year.

Results on the number of close companions of respondents as represented in Table 4.9 show that 6 (5%) did not have anybody that they considered as close companions, 40 (34%) respondents indicated that they had 4-6 close companions. A quarter of the total number of respondents said they had 1-3 close companions, 34 (28%) had 7-9 close companions and finally 10 (8%) had 10 or more companions. Cutrona and Russell (2009) have observed that with advancing age, it is inevitable that people lose connection with their friendship networks and that they find it more difficult to initiate new friendship and to belong to new networks. That the elderly are faced with numerous physical, psychological and social role changes that challenge their sense of self and capacity to live happily. Most elderly persons experience loneliness and depression in old age, either as a result of living alone or due to lack of close family ties and reduced connections with their culture of origin, which results in an inability to actively participate in the community activities.

4.2.3 Research Question 2

What kind of support do the elderly in GED receive from their community (families, religious affiliation and the District Assembly) to enable them have quality life?

This research question was intended to find out the different kinds of support available to the elderly in Gomoa East District as presented in Table 4.10. With regards to the varied kinds of support they received the study revealed that 57 (48%) received financial support from their families. Twenty-eight (23%) indicated that they were helped in cleaning their houses as well as received assistance in laundry work. Eighteen (15%) were assisted in cooking.

Family support is provided in a range of areas such as activities of daily living for example washing and dressing; household management for example preparing meals and shopping and emotional and social support as indicated by Baum and Baum (1980). The family is the immediate and most reliable institution where the elderly can access support therefore if the family fails in rendering this service life become difficult for them. This points to the fact that individuals should invest heavily in their families whilst they are active and financially stable because a time will when they will depend on the family for support in diverse ways.

The study tried to find out the kind of support the elderly received from the government through the District Assembly and the results show in Table 4.11 that the only support given was the registration of the NHIS for 59 (49%) respondents. There was no support as financial, recreational, educational or provision of clothing items. Meanwhile, the Minister of Gender, Children and Social Protection has stated that Ghana has launched a programme for people above 60 years called the "Eban." Elderly welfare card programme is an initiative which provides the elderly priority access to social services in health, transportation and other services (Mawuli, 2015). If the State will make policies for the elderly functional there is the likelihood that the plight of the elderly will be minimized. Sometimes the policies are there but those in the rural areas do not benefit therefore Assembly Members must ensure that the elderly in their catchment area are benefitting from such policies.

The study again touched on the support given by religious bodies as portrayed in Table 4.12. Thirty (25%) respondents received financial support from their religious affiliated groups whilst eighty one (67%) received social support in the form of visitation. None of them was assisted in laundry work, counselling, recreational or

clothing items. Only two (1%) people received support in cleaning the house and seven (6%) of them received food items. For most elderly in society, religion has a major role in their lives, with about half of their population attending religious services at least weekly. Banga (1992) has observed that the religious community is the largest source of social support outside of the family for the elderly. Religion correlates with improved physical and mental health and religious people may propose that a supernatural intervention facilitates these benefits. Most of the responses given by the respondents affirm the Social Exchange theory, which says that people continue social interactions as long as they perceive them to be worthwhile. Nagy (1994) posits that being a member of an association in the religious body or other groups in the society gives them the opportunity to meet and interact with people to break boredom and also enhance their quality of life. He reiterates that it is of great importance that the individual joins a group of interest and attends meetings regularly if their strength would permit them. In his view if for some reasons the individual cannot attend social gatherings, family members should stick close to them as often as possible or once a while take them to social gatherings. He cautioned family members never to deprive them of the access especially if they express the desire to join groups of interest. Religion is a strong pillar for people in times of difficulties including the period of old age which is characterized by challenges. Religion gives meaning to life as well as confidence to face life's challenges therefore almost everyone has put his or her faith in one kind of religion or the other. Again, religious leaders are seen as representatives of supreme deities therefore people take their words serious that is why people affiliate themselves to different faiths in order to hear messages from the supernatural through these leaders. When the elderly go to such gatherings related to their faith, it helps them in diverse ways; socially,

emotionally and even financially since some religious groups remit their members who are old.

4.2.4 Research Question 3

What are the coping mechanisms adopted by the elderly in GED?

This research question sought to bring to light how the elderly coped with the challenges they faced—financial, social and health. The study revealed that majority of the elderly forty four (36%) coped with financial constraints through the financial support given by their families whereas a minority of them 3 (3%) coped by earnings received from babysitting as shown in Table 4.13. Fifteen (13%) relied on the support given by their religious organizations, the same number of people engaged in petty trading to support themselves. People who use religious coping mechanisms are less likely to develop depression and anxiety than those who do not. The elderly persons' level of religious participation is greater than that of any other age group. Banga (1992) asserts that most elderly people report that religion is the most important factor enabling them to cope with physical health problems and life stresses such as decline in financial resources, lose of a spouse.

According to Table 4.13, 5 (4%) begged for money in order to cope with financial challenges. Others 16 (13%) were involved in peasant farming and still others too claimed that they could not do anything at all to support themselves financially. In one study, over 90% of the elderly patients relied on religion, at least to a moderate degree, when coping with health problems and difficult social circumstances. For example, material support and hearing a hopeful and positive

message about the future help people with physical problems remain motivated to recover (Banga, 1992).

Again, on coping strategies the elderly were to indicate how they coped with social challenges specifically with regards to boredom. The results as shown in Table 4.14 indicate that majority 98 (82%) attended funerals and a small representation 12 (10%) said they sat by the roadside to see vehicles and people passing. Others 76 (63%) said they attended religious functions to feel connected with people, 24 (20%) watched Television and 14 (12%) told folktales. Banga (1992) opine that increased social contact by a religious group increases the likelihood that diseases will be detected early and the elderly persons will comply with treatment regimens because members of the religious group interact with them and ask them questions about their health and medical care. Elderly persons who have such community networks are less likely to neglect themselves.

Concerning coping strategies to deal with health challenges Table 4.15 gives a clear picture of how the elderly survived. Ninety (75%) respondents claimed to be using herbal treatment, 18 (9%) visited the hospital and 37 (19%) said they visited community clinics whilst 42 (22%) purchased over-the-counter medicine. Thirty seven (19%) also used spiritual means to ensure good health. Some said they used prayers, others used spiritual directions popularly called (Akwankyere in Akan), whilst other respondents also resorted to the use of amulets.

Not all elderly people are weak and sick so most of them engage in income generating activities to keep them active and also to earn some income. For this reason they engage in a range of activities from selling to farming to stay strong and get occupied. Relatively, young people get more social contacts than the elderly since

they are mostly out of the house. This leaves most elderly people lonely with few people to interact with. So they also devise their own means of coping with loneliness by attending social and religious meetings, just sitting outside of their house to watch and interact with people. Health-wise, the regenerative ability of the elderly to fight diseases is low so they suffer from a range of diseases and they go through physical pain. In order to survive they devise ways and means to handle the situation. They resort to herbal, spiritual and orthodox treatment.

4.2.5 Research Question 4

What kind of impression do the elderly have about the treatment given to them by their family members?

This research question sought to find out the kind of impression the elderly had on the treatment given to them by their family members as presented in Table 4.16. Eighty-two (68%) respondents said that they felt loved in their families, whilst 30 (25%) respondents stated that their family members saw them as a burden. Their responses confirm the assertion of the Caregiver Stress Theorists who propose that neglect of the elderly occurs when family members caring for an older adult are not able to manage their care-giving responsibilities well. According to Burnight (2011), the caregiver stress theory fundamentally tends to view the victim as being very dependent on the caregiver who becomes extremely overwhelmed, frustrated, and abusive because of the continuous caretaking needs of the elderly who becomes the care recipient. Implicit in the caregiver stress theory is the notion that, caring for an elderly appears to be a difficult task which tends to elicit a heightened state of mind-body reaction to external stimuli which tend to induce fear and anxiety in the caregiver. This renders the elderly more vulnerable to neglect.

With regards to respect received from their family members, 26 (22%) respondents indicated they were not respected whereas 94 (88%) indicated that they were well respected. Forty-six (38%) respondents declared that they were not satisfied with the kind of care and support given to them by their family members whilst 74 (62%) said they were impressed and satisfied with the treatment they received.

Caring for the elderly is tedious especially when the elderly do not appreciate the effort of the care-givers, be it family or a hire service from non-family members. This gives rise to the care-giver stress theory and the elderly feel neglected. On the other hand, some family members consider the immense contribution they received from their elderly relatives when they were strong and active and do the same for them. Most elderly people are impressed by the kind of support they receive from their family and feel respected. This encourages the family members to give more support because they are being appreciated and it also helps the elderly emotionally to face life's reality because they have not been neglected.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents a summary of the research study as well as the findings, the study examined the challenges faced by the elderly in Gomoa East District, the functionality of the various kinds of support available to them and how they manage these challenges. This chapter also includes conclusions drawn from the results, their implications and recommendations for further research.

5.1 Summary of Study

The study aimed at examining the functionality of the support systems available for the elderly in Gomoa East District. The objectives of the study were to identify the challenges faced by the elderly in GED; elicit kind of support the elderly in GED receive from their families and the District Assembly to enable them have quality life; examine the kind of impression the elderly have about the treatment given to them by their family members and examine the various coping mechanisms adopted by the elderly in GED.

The population of the study included all men and women aged 65 years and above living in the District at the time of the study. Purposive and snow-balling sampling techniques were adopted to select 120 elderly persons from the District. Structured questionnaire was used to gather all the necessary information for the study over a period of four (4) weeks. Items for the questionnaire centred on age related challenges, the various kinds of support received from their families, religious

affiliation and the District Assembly, the kind of impression the elderly have about the treatment given to them by their family members and also the various coping mechanisms adopted by the elderly in GED. Data gathered was analysed using SPSS version 16 to generate frequency tables which were interpreted and discussed.

The findings of the study are summarized as follows:

a. All the elderly in the study faced health challenges. Health issues were of much concern to the respondents. One hundred and four (87%) out of the 120 respondents complained of multiple health problems, only 16 (13%) respondents were suffering from only one kind of ailment.
b. Almost all the elderly had financial challenges. Only 6% of the 120 respondents indicated that they had no financial challenge.
c. Respondents received great support from their family members. There was a wide range of assistance offered by their family members—financial assistance, assistance in household chores and also accompanying them to the hospital or clinic.
d. None of the respondents received financial, recreational or educational support from the government through the District Assembly. Fifty-nine (49%) respondents were registered into the NHIS by the Assembly. The government had put certain measures in place to assist the elderly but these measures were yet to be accessed by the elderly in Gomoa East District.
e. Some religious organizations provided financial support to their members and also visited regularly. During their visitations, words of encouragement were given to respondents which gave them hope and the sense of belonging.

f. Seventy (62%) of the respondents were impressed with the kind of treatment given to them by their family members. They said they were well catered for and well respected.

g. A quarter of the total number of respondents stated that their families saw them as a burden. They were often insulted by some family members and in some instances branded as witches and wizards.

h. Respondents adopted different kinds of income generating activities in order to cope with the financial challenge. They engaged in baby-sitting, petty trading, farming and even begging for alms. There were still others who said they were too weak to engage in income generating activity.

i. Respondents dealt with loneliness by attending funerals, religious activities, watching television, telling folktales and also sitting by the road side to watch human and vehicular movements.

j. Respondents resorted to different ways of combating ill health.

5.2 Conclusions

Based on the findings of this study, it can be concluded that almost half of the elderly in this study did not have any formal education. These elderly persons faced a number of challenges such as financial, social and health challenges. For this reason they needed some kind of support.

Older people have limited regenerative capabilities and are more prone to diseases, syndromes, and sickness than other age groups. Since the elderly have reduced immune system they are susceptible to all kinds of diseases. That is because the immune system gradually loses its ability to fight off infections as people grow

older. This increases the risk of getting sick and may make immunization less effective as people age. As people grow older the ability of their immune systems to fight against diseases decreases.

It also came out that at that stage in life the elderly would have lost social contact with friends and acquaintances so they are usually lonely. It is known intuitively that relationships are important and contribute to our well-being. It is not the number of family or friends but the quality of relationships that sustains people. Social support is one of the most important factors in predicting the physical health and well-being of everyone, ranging from childhood through older adults. The absence of social support shows some disadvantages among the impacted individuals.

Not only that but also since they are no longer in active service their level of income is usually low. Material family support for older people in Ghana, as in other African countries, has declined in recent decades, exposing increasing numbers especially of urban elderly to destitution and poverty. The nature and causes of this decline remain poorly understood, in particular the relative role of growing material constraints, as proposed by political economic perspectives, or weakening traditional values, as suggested by modernization perspectives.

People who have advanced in age go through a lot of challenges therefore they need support in diverse ways to make life become comfortable for them. The support could come through the provision of good quality health care, adequate social contact, good nutrition and many more. All indications show that the elderly received support from their families but it was not adequate. The respondents who had some form of association with religious bodies received support from that angle.

The Government of Ghana has taken up the responsibility to take care of the aged and have started certain schemes including Livelihood Empowerment Against Poverty (LEAP) to provide care and support for the aged. Yet, the elderly in GED have not benefited from it.

At any age, the family provides the individual with the emotional, social, and economic support (Soldo & Agree, 1988). The ability of the aged persons to cope with the changes in health, income, social activities, etc. at the older ages, depends to a great extent on the support the person gets from his/ her family members.

5.3 Recommendations

i. The results of the first objective of the study showed that every elderly person suffers from at least one ailment. Since it is likely that at old age people spend much on medical expenses it is recommended that people should save well enough towards old age to lessen the burden of financial constraint. Again, at that stage in life, it is likely that the individual will be out of active service so there is the need for proper financial preparation towards old age.

ii. Based on objective number three, it came to light that National Ageing Policy Implementation Action Plan contains commitments to expand poverty reduction programmes for older people yet not all districts in the country have benefited from this programme. District Assemblies should make all policies for the elderly functional in their Districts. Policies including financial support, educational and recreational centres as well as counselling centres for the elderly will be helpful. The District Social Welfare should be well resourced by the government with personnel, logistics and funds to carry out

their social welfare activities including counselling to support the aged on their psychosocial imbalances.

iii. In the quest to achieve the fourth objective, it was found out that some families see their old relatives as a burden therefore ill-treatments are meted out to them. For this reason the Government, religious bodies and other agencies should champion educative programmes on national media to sensitize families on the various ways of caring for their ageing relatives.

iv. Religious organizations should intensify their commitment in supporting the elderly among them since religion is found to play a number of roles in their lives which include being a source of strength, comfort and hope in difficult times. Not only that, but also religion helps the elderly to have a sense of community and belongingness.

v. Ageing is a combination of changes in the body and the impact of what people do with their bodies. Whatever we do to the body which include the food people eat, the intensity of thinking or worry people go through, the body creams people smear on, the amount of sun rays exposed to the body and many more all affect the ageing process. So young people must take good care of themselves in order to age gracefully. Having identified the various challenges faced by the elderly in society, it is being recommended that individuals will check their lifestyle practices whilst they are younger so that health problems will be decreased drastically. For instance, too much of alcohol intake, unhealthy habits of eating, self-medication and everything that will disturb the body later in life must be checked.

5.4 Limitations of the Study

The researcher encountered a number of difficulties during the conduct of the study. The elderly wanted to collect money before giving out information. They did that because some of the NGOs gave out money before information was retrieved from the elderly and therefore the elderly people took this study for one of the NGOs. There was also a challenge of unwillingness on the part of some of the respondents to provide the information for fear of the outcome of the research.

Additionally, financing the project was another issue worth mentioning as a limitation. The researcher would have wished to have visited all the twenty-two communities in the GED but that was not possible. Time was also a major constraint as there was the anticipation to finish the thesis within the university's duration requirement for the completion of the project.

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as there was the anticipation to finish the thesis within the university's duration requirement for the completion of the project.

Collection of data for the research lasted over a period of four weeks, taking into consideration the fact that the researcher had to read and translate the questions from English to the local dialect for them to understand.

5.5 Suggestions for Future Research

This study focused on the various challenges confronting the elderly, the kind of support they receive from their families and the District Assembly, the impression of the elderly concerning the treatment they receive as well as the coping mechanisms adopted by the elderly. Beside these, future research may focus on whether educational background has an impact on a person's ageing processes. Further research should continue to investigate how a person's education influence his or her understanding the impact of ageing on a person's psychological, emotional and physical development.

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APPENDIX

I am an MPhil student at the University of Education, Winneba conducting a study on The Functionality of the Support System for the Elderly in Gomoa East District. I would greatly appreciate a few minutes of your time to answer the following questions. Your answers will be treated in strictest confidence. Thank you very much.

SECTION A: DEMOGRAPHIC DATA

1. Gender M[ ] F[ ]

2. Age
   - 65-69 [ ]
   - 70-74 [ ]
   - 75-79 [ ]
   - 80-84 [ ]
   - 85-89 [ ]
   - 90+ [ ]

3. Marital Status
   - Married [ ]
   - Widowed [ ]
   - Divorcee [ ]

4. How many children do you have?
   - None [ ]
   - 1-4 [ ]
   - 5-9 [ ]
   - 10+ [ ]

5. Educational background
   - No Formal Education [ ]
   - Elementary [ ]
   - Secondary [ ]
   - Tertiary [ ]

6. Former Occupation

Teaching [ ]

Farming [ ]

Fishing [ ]

Trading [ ]

Artisan [ ]

Others(Please specify)……..

SECTION B (CHALLEGES FACED BY THE ELDERLY)

Objective One: The study seeks to explore the various challenges that the elderly in GED face.

7. What are some of the challenges you face as an elderly person?

Financial [ ]

Health [ ]

Social [ ]

Emotional [ ]

Others (specify) .....

8. How many friends/neighbours do you feel close to that you can call on for help?

9 or more [ ]

5-8 [ ]

3-4 [ ]

2 [ ]

1 [ ]

9. With how many friends/neighbours can you comfortably discuss private matters?

9 or more [ ]

5-8 [ ]

3-4 [ ]

2 [ ]

1 [ ]

10. How often do you have someone who shows you love and affection if you need it?

    Always [ ]
    Very often [ ]
    Often [ ]
    Sometimes [ ]
    Never [ ]

11. How often do you have someone to share your most private worries and fears with if you feel wanted?

    Always [ ]
    Very often [ ]
    Often [ ]
    Sometimes [ ]
    Never [ ]

12. How often do you participate in social groups/organization? For example, recreational group, community organization, political group, religious organization.

    Always [ ]
    Very often [ ]
    Often [ ]
    Sometimes [ ]
    Never [ ]

HEALTH CHALENGES

13.

Which of these diseases have you been diagnosed of?	Diabetes [ ]
	Hypertension [ ]
	Arthritis [ ]
	Cancer [ ]
	Hernia
	Others (specify) ----------

14.

	Excellent	Very Good	Good	Poor	Very Poor
How would you rate your sight?					
How would you rate hearing					

15. Please indicate if you get support in performing the following activities.

Activity	No support	Support from Family	Support from Neighbours
Meal preparation			
Cleaning the house			
Laundry			

FINANCIAL CHALLENGES

16. Please indicate your source of income.

Sources of Income	
Full time work	
Part-time work	
Children	
Friends	
Neighbours	
Pension benefits	
Beg for money	

SECTION C: SUPPORT FOR THE ELDERLY (Support from family).

Objective Two: To identify the different kinds of support that the elderly in GED receive from their families.

17. Whom do you live with? Spouse [ ] Children [ ] House help [ ] Family member(s) (Specify) [ ] Alone [ ]
18. How often do you meet up with any of your children/family members? (Not counting any who live with you). Daily [ ] weekly [ ] monthly [ ] yearly [ ]
19. How often do you speak on the phone with any of your children/family members?(Not counting any who live with you). Daily [ ] weekly [ ] monthly [ ] yearly [ ]
20. I can rely on my family if I have a serious problem? Strongly agree [ ] Agree [ ] Somehow [ ] Disagree [ ] Strongly disagree [ ]

21. How often do you feel you lack companionship, left out or felt isolated? Very [ ] Often [ ] Some of the time [ ] Hardly ever [ ]
22. How many relatives or family members do you feel close to that you call for help

    9 or more [ ] 5-8 [ ] 3-4 [ ] 2[ ] 1[ ]

23. With how many relatives or family members can you comfortably discuss private maters? 9 or more [ ] 5-8[ ] 3-4 [ ] 2 [ ] 1[ ]

Support from the District Assembly (Objective Three). To identify the various support systems provided by the District Assembly for the elderly.

24. Are you a member of the National Health Insurance Scheme? Yes [ ] No [ ]
25. If 'Yes' who registered you? Self [ ] Children [ ] District Assembly [ ]
26. Do you know about any policy for the elderly? [ ] No [ ]
27. If 'Yes' which of them are you familiar with .....
28. If 'No' why? Financial constraint [ ] Inferior medicines are served [ ]
29. How much do you receive from the District Assembly as allowance? GH$200-GH$100 [ ] GH$90-GH$40 [ ] None [ ]
30. How often does the allowance come? Monthly [ ] Quarterly [ ] Every 6 months[ ]Yearly [ ]
31. Has the District Assembly organized any Educational or Recreational programme for the elderly before? Yes [ ] No [ ]
32. If Yes, which programme? Please indicate.....

SECTION D: VALUE PLACED ON THE LIVES OF THE ELDERLY.

Objective Four: To ascertain the kind of value families place on the lives of their ageing relatives in the GED?)

33. What kind of contribution did you give to your family and community before you became an elderly person?

Invested in my children's education [ ]

Invested in other people's education [ ]

Acquired a piece of land for the family [ ]

Acquired a farm for the family [ ]

Built a family house [ ]

Others (Please specify)……..

34. What kind of contribution do you offer to your family and community?

Take care of children when their parents are not around [ ]

Give pieces of advice [ ]

Help in planning events such as marriages, naming etc. [ ]

Others(Please specify)…….

35. How often do family members criticize you? Always [ ] Very often [ ] Often [ ] Sometimes [ ] Seldom [ ] Never [ ]

36. How often do they let you down when you are counting on them? Always [ ] Very often [ ] Often [ ] Sometimes [ ] Seldom [ ] Never [ ]

37. I find my household friendly. Strongly agree [ ] Agree [ ] Somehow [ ] Disagree [ ] Strongly disagree [ ]

38. How often do family members use demeaning expressions at you? Always [ ] Very often [ ] Often [ ] Sometimes [ ] Seldom [ ] Never [ ]
39. Do you think the value placed on the elderly have changed in anyway? Yes [ ] No [ ]
40. If yes what do you think has accounted for such changes
41. What are some of the demeaning expressions used at you?(If your previous answer was not 'Never') Witch [ ] Worthless [ ] Useless [ ] Others (specify)
42. Some family members say or show sign(s) that I am a burden to my family. Always [ ] Very often [ ] Often [ ] Sometimes [ ] Seldom [ ] Never [ ]
43. The older I get, the more useless I feel. Strongly agree [ ] Agree [ ] Somehow [ ] Disagree [ ] Strongly disagree [ ]
44. I wish I were dead. Strongly agree [ ] Agree [ ] Somehow [ ] Disagree [ ] Strongly disagree [