THE EMERGING PROBLEMS OF THE AGED IN GHANA: ISSUES OF HOUSING AND BASIC CARE A CASE STUDY OF SOME SELECTED DISTRICTS IN ASHANTI REGION

BY

ALEX ANNING

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DECLARATION

I hereby declare that this is my own work towards the MSc. Development Policy and Planning and that, to the best of my knowledge; it contains no material previously published by another person or material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

Alex Anning (PG 3282409)	…….	……
(Name of Student and ID)	Signature	Date

Certified by:

Mrs.Dina Adei	…….	……
(Supervisor)	Signature	Date

Certified by:

Dr. Daniel K. B. Inkoom	…….	……
(Head of Department)	Signature	Date

ABSTRACT

The issue of the aged particularly in Ghana has become a major concern to the government in particular and society in general in recent years. In view of this, a number of policies have been put in place to reduce the burden on the people including the aged. Notwithstanding, the conditions of the aged have not changed. The study sought to investigate into the healthcare, housing, social and financial issues of the aged, and examine the various policies meant to support their wellbeing in Kumasi Metropolis and Bosomtwi District within Ashanti Region.

Purposive sampling technique was adopted for the selection of the study area while snowballing was used in locating the respondents. Interview guide and questionnaire were used for the collection of data from the respondents. Mathematical formula with five percent margin of error was used in determining the sample size of 264. The statistical package for the social sciences (SPSS, 2007 version) was then used for the analysis of the data.

The survey revealed that about 63 percent of the aged depend on remittances and philanthropic support from children and other source, while 36.7 percent depend on pension and other investments. The cost of living for the aged is relatively high, about 77.4 percent of their expenditure goes into food. Agriculture sector employs 42.4 percent an increased from 32.2 percent before retirement age. Seventy-eight percent of the aged either live in rented or family house. Only 22 percent owned their house. About 93 percent uses KVIP and pit latrine and 80.7 percent access it outside their house. About 90 percent also have access to potable water and these have health implications. About 64 percent of the aged have either divorced or widowed and therefore suffers loneliness, 47 percent use visitation of friends to break boredom and reduce their stress level. Self-medication was found to be a frequent habit among the aged, as 63 percent rely more on medicine to sustain their health conditions. About 58 percent of the aged suffer from a multiple or more than one illness while 24 percent had bodily/joint pains.

Beside SSNIT pension scheme which is documented in the National Aged Policy and largely skewed towards those in the formal employment, there was no other policy directly made to support the aged. The institutions such as the Religious group, the Assembly, the Social Welfare and other NGOs also have no clear and direct policy towards supporting all aged. All the age cohorts, thus, the youth, the adult and the aged are dealt with as one unit and made to

compete for the socio-economic interventions by the state leading to the aged being competed off.

It was recommended that, a fund be put in place called “aged fund” which would seek to ensure the aged wellbeing. The age at which one qualifies for a free or subsidized premium payment of the national health insurance scheme should be reduced to 65 years. Long term housing policy be established to ensure that every worker have his/her own house before reaching the retirement age. Social centres should be put in place in the communities to improve their social interactions.

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LIST OF ACRONYMS/ABBREVIATIONS

AIDS	-	Acquire Immune Deficiency Syndrome
BDA	-	Bosomtwi District Assembly
CBD	-	Central Business District
CBSV	-	Community Based Surveillance Volunteers
CAAF	-	Compassionate African Aged Foundation
DA	-	District Assembly DSW
DACF	-	District Assembly Common Fund
DPCU	-	District Planning Coordinating Unit
FCUBE	-	Free Compulsory Universal Basic Education
GSGDA	-	Ghana Shared Growth and Development Agenda
GLSS	-	Ghana Living Standard Surveys
GSS	-	Ghana Statistics Survey Goals
HIV	-	Human Immune Virus
ICPD	-	International Conference on Population and Development
KMA	-	Kumasi Metropolitan Assembly
KVIP	-	Kumasi Ventilated Improvement Pit
LTCI	-	Long Term Care Insurance
LEAP	-	Livelihood Empowerment Against Poverty
MESW		Ministry of Employment and Social Welfare
MDG	-	Millennium Development
MIPAA	-	Madrid International Plan of Action
NDPC	-	National Development Planning Commission
NGOs	-	Non-Governmental Organizations
NHIS	-	National Health Insurance Scheme
NORC	-	Naturally Occurring Retirement Communities
PO	-	Planning Officer
RPC	-	Regional Programmes Coordinator
SF	-	Sample Frame
SS	-	Sample Size
SSNIT	-	Social Security and National Insurance Trust
TB	-	Tuberculosis
UN	-	United Nations

UNCHS	-	United Nations Centre for Human Settlements (Habitat)
UNDP	-	United Nations Development Programme
UNEP	-	United Nations Environment Programme
USAID	-	United States Agency for International Development
VAT	-	Value Added Tax
WC	-	Water Closet
WHO	-	World Health Organisation

CHAPTER ONE

GENERAL OVERVIEW OF THE STUDY

1.1 Introduction

The issue of the aged has become a major challenge in the world as a whole and Ghana in particular. As people grow old, they frequently encounter peculiar problems in finding suitable living arrangements in terms of housing, basic care and other health needs, but little attention seem to have been given by governments over the years and society in general to how older persons and their families attempt to deal with these problems(Robinson, 2006).

This issue became pronounced when it was realized that, the aged population (65 years and above) is increasing, while the younger section of the population is decreasing (Lagergren, 2004). This changing demography is an international trend where Ghana is no exception. For example, in1950, there were about 200 million people over60 years of age worldwide; by 1975, this number had increased to350 million and expected to reach 1100 million by the year 2025.By the year 1975, half of the population of over60 years of age lived in the developing countries; this figure is expected to increase to approximately 72 percent by 2025 (Schwab, 1989).

The aged population in Ghana experienced an increased from 4.0 percent in 1984 to5.3 percent in year 2000 (GSS, 2005) and expected to increase further. Their situation is expected to aggravate in the bid to achieving the objectives in the Millennium Development Goals (MDG) if nothing concrete is put in place in catering for their wellbeing. A situation where more people would be expected to cross over the life expectancy of 61 in Ghana currently or life expectancy is expected to increase worldwide as an objective of the MDG. The emerging issues affecting the aged in Ghana are numerous; however, the study seeks to look at housing, and basic care.

The major concern of the elderly especially in Ghana includes the basic care required from the society which includes the society appreciating/understanding their psychosocial, physiological and economic situation that would make them have a decent and meaningful life while they live. This contributes immensely to their health stability (Reed, 2007). As one increases in age, the level of loneliness worsens due to a limited social network and as a

result of rejection and or denial, immobility or the death of friends and partners(Andersson, 2002).The Basic Care for the aged has become a great challenge to the Ghanaian society as a result of the gradual breakdown of the extended family system and the compound housing system where each family member sought some support and comfort: about 40.6percent of the household in Ghana live in separate/semi-detached houses as against 44.5percent of the households live in compound houses (GSS, 2005).

Housing is also another area of concern to the aged particularly in Ghana, this is because, housing could influence socio-economic and health conditions of the individual. Not less than 43percent of the household population in Ghana either live in rented houses or in kiosks (GSS, 2005); indicating that, the over 43percent of the population who live in the rented houses risk to be homeless whenever they ceased working to earn income to meet their accommodation expenditures. This may be possible, especially where extended family system continues to breakdown. For example, in Kumasi alone, about 74 percent of the population has no permanent housing accommodation; while some are renting, others are squatting or perching (UN-HABITAT, 2010) and they might likely remain homeless when the expenditure for housing accommodation becomes unsustainable to the poor tenant.

The aged population is increasing worldwide, however in most developing countries including Ghana; it is believed that most of the aged experiences somewhat rejection or limited care from the society including governmental levels. This has the tendency to affect their psychosocial and physiological lives which could lead to multiple sicknesses eroding their health conditions and making ageing a resemblance of misery and curse instead of blessing, peace and restful period. Culturally, there is an Akan adage which says, "Consulting or asking the old lady" literally means seeking the wise counsel of the age, when there is a critical and concrete decision needed to be taking. This presupposes that traditionally the aged is regarded as fountain of knowledge and wisdom and also transfer knowledge, skills, expertise and historical facts to the younger ones when necessary due to the experiences they might have gone through in life (MESW, 2010). If the appropriate policies relating to their socio-economic welfare are considered, their existence would be beneficial to the society rather than seen as a burden.

1.2 Problem Statement

Many countries in Sub-Saharan Africa like Ghana have young population, but due to changes in demographic trends and profiles, these countries are growing steadily with an increasing elderly population. However, little and in some instances almost no attention has been paid to the wellbeing and health needs of the elderly in society (Robinson, 2006). For example, the latest updates on the United Nations' Millennium Development Goals (MDGs) show very poor progress in Sub-Saharan African countries in its target of eliminating extreme hunger and poverty (UN, 2008);this rendering the economically active population incapable to support the aged financially, neither are the aged able to make the necessary savings towards their ageing period. This however is worrying, since quality of life and access to proper healthcare may depend on the economic ability of the individual (GSS, 2005).

In this direction, majority of the aged may lack the necessary financial resources to meet their accommodation needs when they do not own a house. The aged particularly the retired, mostly have unsustainable income and may depend on their pension benefits (if he/she was a contributor to the pensions scheme or personal private investments if he/she was able to save enough) to sustain him/herself financially. Due to relatively, low income of most employees, savings usually may be low and pension benefits are also low. Some may also depend on remittances from relatives which may also not be sustainable due to harsh economic situations. Worse still, about 80.4 percent of the population in Ghana, are in the informal employment especially trading and farming and might not be able to make enough contributions towards meeting their housing needs during retirement or incapability (GSS, 2005).

Secondly, some of the aged may be burdened in adapting to the new environment and the use of its modern and sophisticated housing facilities which was previously unknown to them including the use of microwaves, gas cookers and others. The desire to work in the cities and have good education for oneself and children may contribute to the increase in rural-urban drift and this has necessitated people moving their aged relatives to stay with them in the cities. Some aged on the other hand, may prefer to move away from the hustle and bustle of city life to the village after retirement or have become older and frail. Having become used to city life and its modern housing facilities, it is sometimes difficult adapting to the not very familiar village facilities. This includes fire wood, kerosene lantern and the quiet environment

in most of the afternoons where their socio-cultural and economic exposure might be at different level with that of those in the village. These situations have the tendency to limit their level of interaction as well as creating a sharp difference between city and village life.

Again, security in the life of the aged is an important aspect of their wellbeing and this could be attained through social support and social network. One of the major problems of the aged is loneliness(Andersson, 2002), as a result of the loss of friends and spouse including relatives of the aged due to either sickness of the aged, death of spouse or rejection by relatives of the aged. Another problem is inappropriate social support; the aged may feel good emotionally and physically when they have personal attendant and/or peers to interact with regularly and also provided with support when necessary. However, they are usually at home unattended to in most of the time where all able bodied persons are out on their usual daily activities including work and school. Worse still, people who are made to give social support to the aged, sometimes may lack the understanding of the psychological, social as well as the physiological changes of the aged and treat them badly to the extent of sometimes associating them with witchcraft.

The health needs of the aged cannot be dissociated from their wellbeing; there is a greater incidence of acute and chronic diseases that affect the aged which may limit their activeness and mobility. It is argued that, "ageing and sickness is a bed fellow", as one increase in age, the effectiveness of the immune system reduces and this affects their resistance to diseases which include arthritic, rheumatic, cardiac and pulmonary conditions (Tinker, 1984). This may render ageing very expensive with little or no support for them. This is because, the national health insurance scheme in Ghana gives exemption of premium payment to the 70 year old and above leaving those between 60 and 70 years to their fate; though, they may be formally retired or unemployed. Even where there is national health insurance support, not all the diseases that affect the aged qualify for free treatment under this health insurance scheme (MIPAA, 2007).

As a result of the various issues such as, financial difficulty, social problems as well as health challenges confronting majority of the population in Ghana which include majority of the aged, government has put in place social intervention policies. These include the free compulsory universal basic education (FCUBE) and school feeding programme, National Health Insurance Scheme (NHIS), livelihood empowerment against poverty (LEAP) fund,

SSNIT and other pension schemes, subsidized transportation scheme, low cost and affordable housing schemes. All these were geared towards reducing the burden of the ordinary people including the aged. Notwithstanding these policy interventions, the poverty and vulnerability of the people still persist with the number even increasing especially the aged (NDPC, 2010).It is in the light of this that a study on the emerging problems of the aged with respect to housing and basic care is being conducted using Ashanti Region as a case study to investigate the causes of these problems and how they could possibly be reduced if not solved completely for national development.

1.3 Research Questions

The research seeks to find answers to the following questions based on the problem statement above:

- Who is an aged in the society?
- What has been the basic care and housing situation of the aged?
- Why should the aged be supported financially and socially?
- Have the policies and programmes of the aged (if any), at the national and local levels adequately supported their wellbeing?

1.4 Research Objectives

The general objective of the research is to examine the problems of the aged and actions that has been taken to reduce the effect of the problems and make recommendations to inform policy.

The specific objectives of the study are; to

- Analyze who an aged is;
- Assess:
    - the source of financial support to the aged;
    - the housing and health care situation of the aged;
    - the level of social support to the aged;
- Examine the various policies meant to support the wellbeing of the aged; and
- Make recommendations to inform policy.

1.5 Scope of the Study

Geographically, the study was carried out in Kumasi Metropolis and Bosomtwi District within Ashanti Region due to proximity and cost effectiveness and also for the fact that, it is cosmopolitan and gives diversity of ethnicity. The Kumasi Metropolis and Bosomtwi District were selected in order to give the diversity of highly urban and relatively rural communities in relation to the care of the aged. The survey was done within the following communities; Bomso, Oforikrom, Anloga in the Kumasi Metropolis and Jachie, Kuntenase and Apenkra in the Bosomtwi District. The reason was that, these communities exhibited most of the characteristics such as farmers, civil servants and teachers, traders and industrialists which is of interest to the study. Again, there was also a strong organized aged group in these communities which facilitated their easy access. This approach was adopted because it was possible that the aged may not be found or located in every home.

In terms of content, the study covered the financial and social support, health and housing conditions of the elderly, aged 65 years and above within the geographical scope.

With respect to time scope, the study sought to assess the issues of the aged as listed in the content above within the research period that is, between January and December, 2012.

1.6Justification of the Study

It is an undeniable fact that, old age is what everyone aspires to whether rich or poor, employed or unemployed. As soon as one enters the world, the clock of age starts ticking, yet that is the area where the society as a whole have not made a conscious effort to tackle holistically but left to the individual to handle. It is also an area where it seems not much study has been done in terms of research, especially in the developing countries, particularly Ghana.

Again, one can attribute the numerous corrupt practices in this part of the developing world like Ghana to the uncertain future that everyone is afraid of and finding every means of making provision for in order not to be caught “pants down”. It is a period that its happenings looks highly unpredictable and everyone speaks of with some mixed feelings. It is also the period which is directly related to chronic diseases and vulnerability, social services and social protection needs (Tinker, 1984; MESW, 2010).It is believed that, when appropriate

policies are put in place in relation to the wellbeing of the aged, their general lives would improve irrespective of one's socio-economic standing at both the national and local levels. This would help allay the fears of the populace in the uncertainties of the future and reduce its accompanied frustrations, corruption and avoidable deaths among the people of that age for total development of the nation.

In sum, this study has added to knowledge and provides important information for these categories of stake holders, namely; the aging population, the government and policy makers as well as, future researchers and Non Governmental Organisations. Directions have been given on which important areas to base future research so far as the wellbeing of the aged is concerned. Also findings and recommendations will help stakeholders to improve upon practices. Policy makers and interested Non Governmental Organisations would know how best the policies and programmes on the welfare of the aged can be improved to make the aged appreciative and beneficial to the society in general and the state as a whole.

1. 7 Limitations of the Study

The researcher encountered some difficulties during the data collection stage. Some of the religious bodies felt guilty and betrayed to answer the questions. This is because they felt exposed for not doing certain things they should have done in relation to the aged who were vulnerable and excluded. Again some of the institutions, especially the District Assembly and the Department of Social Welfare were reluctant as to who should answer the questionnaire. The Assembly argued that it only finances and monitored the programmes of the Social Welfare when necessary while the Department of Social Welfare also argued that they implement the programme when there was finance. Another challenge, according to report, was that some of the NGOs give some money before information was retrieved from the aged and they 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, especially their incomes and expenditures. However, as a result of further explanations and dialogue, these limitations were overcome and the necessary information needed was received in a friendly atmosphere.

1.8 Organization of the study

The study has been organized under five main chapters. The first chapter gives the general introduction of the research, defines the main problem under investigation and research questions. It further states the specific objectives of the study, defines its scope, and justifies the relevance of the study and finally outlines the limitations of the research.

The second chapter reviews the relevant literature on the emerging problems of the aged which includes the issues of healthcare, social, financial and housing situations. The chapter also provides the theoretical and analytical background needed to design a methodology for the research. The third chapter gives a brief profile of selected Districts of the study area. This includes location and size, social services and the economy. It also contains the research design adopted, the data requirement and the sources of the data, the data collection tools employed, the sampling technique, the key data variables and the framework for data analysis and reporting. It also provides a guide as to the conduct of the field survey.

The fourth chapter presents an in-depth analysis of the primary data collected from the field. It also provides answers to the research questions and forms the basis for the recommendations made to ensure the wellbeing of the aged. The fifth chapter which concludes the study brings out the findings and policy implications of the study. It also offers recommendations and draws conclusions to ensure the wellbeing of the aged for national development.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses into detail the meanings and theories or concepts of ageing. The housing issues of the aged which includes their various housing arrangements would also be reviewed. In reviewing this, the issues of basic care such as financial, social and healthcare would be discussed in relation to case studies and finally, the summary and conclusions of this literature would form the basis for the field study and ensuring the wellbeing of the aged.

2.2 Meanings and Theories/Concepts of Ageing

2.2.1 Definition of Ageing

According to Stuart-Hamilton (2006), the term "ageing" is somewhat ambiguous and said distinctions may be made between "universal ageing" (age changes that all people share) and "probabilistic ageing" (age changes that may happen to some, but not all people as they grow older, such as the onset of type two diabetes). They further argued that, chronological ageing refers to how old a person is, arguably the most straight forward definition of ageing may be distinguished from "social ageing" (society's expectations of how people should act as they grow older) and "biological ageing" (an organism's physical state as it ages). There is also a distinction between "proximal ageing" (age-based effects that come about because of factors in the recent past) and "distal ageing" (age-based differences that can be traced back to a cause early in person's life, such as childhood poliomyelitis).

Ageing in general has been explained, according to Bowen and Atwood (2004), as the accumulation of changes in an organization or object overtime. Ageing in human, on the other hand, could be explained or referred to as a multi-dimensional: physical, psychological and social change. Differences and divisions are sometimes made among populations of elderly people such as the young old (65–74), the middle old (75–84) and the oldest old (85+). However, problematic in this is that chronological age does not correlate perfectly with functional age, i.e. two people may be of the same age, but differ in their mental and physical capacities (Bowen and Atwood, 2004). Different societies and institutions including governmental and non-governmental organizations have different ways of classifying age.

For example, as the formal sector in Ghana classify pension age as 60 years, the Informal sector, classify old age as how far ones health could lead him/her whilst the national health insurance scheme consider 70 year old as aged. Therefore, this study would consider 65 years and above as an aged.

2.2.2 Concepts of Ageing

The process of ageing, according to Eliopoulos (2001),is complex, but not a disease; the principles of gerontological nursing practice, look at ageing as a natural process common to all living organisms. There are many theories which seek to explain the process of ageing. The uniqueness of the ageing process is influenced by both exogenous and endogenous factors such as heredity, nutrition, health status, life experience, environment, activity and stress. Within gerontological nursing, the process of ageing is usually explored from both biological and psychosocial perspectives.

Redfern et al. (2006) reported that, as one ages, the number of cells in the body is gradually reduced. Reduction in lean body mass, total body fluid and increase in fat tissue occurs and these changes affect the maintenance of homeostasis which leads to a decline in functional competence of the individual. Therefore, the elderly may experience that it takes more time for the body to return to 'normal status' when the body has been exposed to any form of physiological stress. Biological ageing process differs not only from one person to another but also from one system to another within the same person. Decline in physical capacities due to changes in cardiovascular system, respiratory system, and muscle mass, body joints, cartilages and collagens affecting physical activity is another aspect of ageing that is obvious in the process. Although most elderly are basically active, it is common to hear them say 'it is not at all like before'. One can link this to the theory of wear and tear, whereby the human body is compared to a complicated machine functioning less efficiently with prolonged usage (Eliopoulos, 2001).

In order to understand the uniqueness of ageing, it is essential to understand the psychosocial aspects of ageing. Factors that are likely to be an influence are the psychosocial process of ageing, physical and mental health, social and family network and cultural beliefs. The psychosocial ageing process can be described through the disengagement theory, the activity theory, the developmental tasks in ageing and gerotranscendence (Eliopoulos, 2001).

Elaine Cumming and William Henry developed the disengagement theory which proposes that as a person ages he or she disengages him/herself from society and the ageing individual uses this period to reflect on life and society and experiences a transfer of power from the aged to the younger. This theory has been classified as controversial and has attracted a lot of criticism as in a way encourages inactivity in old age (Eliopoulos, 2001).

Eliopoulos (2001) further stated that, the opposite of disengagement theory is the activity theory which states that one should carry on with a middle-age lifestyle as long as possible. Society should treat the elderly as it treats the middle-aged. Thus, when activities diminish due to poorer capacity because of the process of old age; efforts should be made to replace these activities with others that are more suitable to the capacity of the elderly. This theory is better accepted, but critiques are of the opinion that the theory does not accommodate to elderly who prefer to retreat at old age. Some theorists say that the psychological process of ageing is a process of fulfilment of developmental tasks. If the fulfilment is successful then one has aged successfully. If one finds meaning in the life that one has lived, then this will assist the person in coping well with the process of ageing.

A recent psychological ageing developmental theory called the gerotranscendence theory, according to Professor Lars Tornstam, proposes that ageing involves transition from a "rational, materialistic met perspective to a cosmic and transcendent vision" (Tornstam, 2005). It states that the human development is a lifelong continuing process and suggests a model for the psychological development in elderly, where the core is to be satisfied with life. Often the gerotranscendent people experience a redefinition of themselves and might also re-evaluate the relationships towards other people. The theory incorporates developmental and existentialistic elements and proposes that the person becomes less self-occupied and also more selective in his/her choice of social and physical activities.

According to National Ageing Policy of Ghana, (MESW, 2010) population ageing is the increase in the number and proportion of older people in society. Population ageing has three possible causes: migration, longer life expectancy (decreased death rate), and decreased birth rate. Ageing has a significant impact on society. Young people tend to commit most crimes; they are more likely to push for political and social change, to develop and adopt new technologies, and to need education. Older people have different requirements from society and government as opposed to young people, and frequently differing values as well. Older

people are also far more likely to vote or directly participate in national electoral decision, and in many countries including Ghana, the young (less than eighteen years with respect to Ghana) are forbidden from voting or directly participate in electoral decisions according to the 1992 Constitution of Republic of Ghana. Thus, the aged have comparatively more political influence. It is a common knowledge in Ghana that the aged are traditionally regarded as fountain of knowledge and experiences and has this parlance "consultation of old lady" on critical decisions and issues such as alternative dispute resolution.

2.3 Issues of the Aged

The emerging problems of the aged are numerous and varied, however, this study would consider the issues of housing and basic care which are more fundamental to the wellbeing of the aged in the society.

2.3.1 Housing/ Housing Arrangements

Housing has been defined by different people in different contexts to suit the condition of that environment. For instance, 2000 population and housing census, housing was defined in terms of shelter, that is, any enclosure with roof and this includes kiosk. However, for the purposes of adequate health and security, this study will adopt the definition of housing as a means of fulfilling physical needs by providing security and shelter from weather and climate. It fulfils psychological needs by providing a sense of personal space and privacy. It fulfils social needs by providing a gathering area and communal space for the human family, the basic unit of society. In many societies, it also fulfils economic needs by functioning as a center for commercial production (UN-Habitat, 1996).

Appropriately, the wish of every elderly person is to have retired to homes of their own and not in any form of residential care. However this has become a myth to majority of this group. Adequate housing is of importance to the elderly in many ways – to keep them warmth, easy access to lavatory and other facilities, less stress in a future rearrangement of tenancy agreement as well as cost, conducive surroundings and above all desire/ability to live in the way they want in their own home (Schwab, 1989).

2.3.2 Types of Housing Arrangements

In Ghana, the main types of housing arrangement familiar to the society include rented housing arrangement, owner occupier housing arrangement and homelessness/slum.

Owned Housing/Homeownership

Nationally, Ghana Statistical Service (2005) reported that, only about 43 percent of the population in Ghana owns a house. The American Housing Survey (1997) report indicated that about 67 percent of American households own their own homes. The report further assessed that, one of the most fundamental needs of the elderly nationwide is - the need for safe and affordable housing linked to appropriate services. Again, Housing Our Elders report revealed that older Americans live in quality housing that is within their means and located in neighbourhoods that they preferred (American Housing Survey, 1997).

The majority of the aged population in Ghana sometimes lacked a decent housing accommodation due to either poverty or denial/rejection by their relatives. Available statistics from Ghana Living Standard Survey indicate that, the informal sector's share of total employment increased from 80.5 percent in 1988 to 88.6 percent in 2006. This includes farmers especially the food crops as well as fishing farmers and traders who are largely associated with poverty. Again, poverty studies in Ghana, including various Ghana Living Standard Surveys (GLSS), have indicated that poverty has increased in predominantly food crops producing areas and fishing communities of Ghana (NDPC, 2010).This therefore suggests that, the earnings of the people in these communities may be low which may not afford them the opportunity to own a house to ensure adequate housing security; they may be either renting, perching or uncomfortably living in a family house.

According to NDPC (2006), only about one in ten Ghanaians had access to secure housing. This implies that, most Ghanaians live under insecure housing tenure conditions and face the problem of possible eviction. Again, one in five Ghanaians live in slum areas with poor access to basic infrastructure including water, electricity supply, proper drainage system and poor sanitation which may go a long way to affect their health condition negatively.

Rented Housing

This is where a contractual agreement between a house owner referred to as landlord/landlady and an occupier also referred to as tenant for a colossal sum of money referred to as advance payment for a specific period of time usually twelve months and sometimes renewable. This sort of agreement is seen to be a very burdensome among Ghanaians especially the poor and the vulnerable including the aged. According to NDPC (2006), nine in every ten Ghanaians live under insecure housing tenure conditions and face the problem of possible eviction/ejection. Ghana Statistical Service (2005) also reported that, about 43 percent of the household population in Ghana lives in rented houses. Statistics has also shown that in Kumasi, as many as 57 percent of the population live in rented houses and this includes the aged population as well as those whose ages are close to the aged population (UN-HABITAT, 2010).

Homeless/Slum

On housing delivery, according to the Minister of housing and water resources, Ghana's housing deficit is over one million. In order to reduce this to ensure that the majority of the people have access to housing accommodation, there is the need to produce housing at the rate of 100,000 per annum. However, the total supply rate is approximately 35 percent annually. This implies that about 65 percent of the total housing needs are not met putting pressure on the few supply and as Brux (2008), put it *"homes in areas with healthy economies and growing populations tend to gain in value over time, whereas the value of houses in depressed regions with declining populations goes down"*. This has made some of the Ghanaian population homeless due to high demand over supply of housing. UN-HABITAT (2010) reported that, not less than 17 percent of the population in Kumasi is homeless.

Causes of Slum/Homelessness

According to NDPC (2010), the rapid increase in population has resulted in a large housing deficit, especially in urban areas. Due to imbalances in the supply and demand of housing, it has resulted to what is regarded as illegal settlement or slum. The cumbersome nature of land acquisition procedures and weak enforcement of development control and standards or codes in the design and construction of houses; ineffective rural housing policy; and haphazard land development has contributed to this slum. Another major challenge relates to housing according to the document, is housing finance. This is reflected in inadequate finance to

support the construction industry; high cost of mortgages; and low production of, and poor patronage of local building materials are some of the causes of homelessness and slum.

2.4 Basic Care of the Aged

This section discusses the following issues such as Social Support, Living Arrangements of the Aged, Health life of the Aged and Financial /Income Support to explain the understanding of basic care of the aged.

2.4.1 Social Support

Caring according to Lindberg-Sand (1993) is a universal term which is not bound the nursing profession. The caring perspective origins from humanity but also involves practical accommodation of basic human needs. The acts that determine caring are those done together with another person, healthy or ill, to achieve optimal health or quality of life.

One of the greatest fears people have about ageing according to Daniel et al (1993; MESW, 2010), is the potential loss of independence and the possibility of being institutionalized. Both the young and old alike together associate ageing with increasing fragility and a growing dependence on others for personal care. The typical scenario is one in which the elderly person's needs and demands eventually become a burden on family members, who are then forced to move their aged relatives to a nursing home or others abandoned them while others also move them from the village to stay with them. As "everyone knows", nursing homes are little more than "human warehouse" where the elderly are isolated from their families, experience loneliness and depression and wait docilely for death (Daniel et al, 1993). Yet the fact is that only about five percent of those aged 65years and above in the United States is living in nursing homes, and recent evidence suggests that in some cases nursing home life can have a positive impact on the elderly and their families (Smith and Bengston, 1985).

2.4.2 Living Arrangements of the Aged

This explains how an individual or a group of persons in the United States organizes their living situation. Either living with the spouse if married or living with other family members or living with own family or living alone. Some of the aged live alone while others live with

caregivers or non-relatives. Ideally however, every aged should live with somebody for support and to reduce stress. Others have argued that, it is rather a period where one needs personal care as Table 2.1 portrays.

Table 2.1: Living Arrangements of Persons of 65 Years and older by Sex – 1989 (USA)

Sex	Age Cohort (in Years)	Percentage Living			
		Alone	With spouse	With Other Relatives	With Non-Relatives
Women	65	40.9	40.1	17.8	1.2
	66-74	33.5	51.4	14.1	0.9
	75+	51.2	24.3	22.9	1.6
Men	65	15.9	74.3	8.4	1.4
	66-74	13.3	78.4	7.2	1.2
	75+	20.7	66.7	10.9	1.7
Average	65	28.4	57.2	13.1	1.3
	66-74	23.4	64.9	10.6	1.1
	75+	35.9	45.5	16.9	1.6

Source: US Department of Commerce, 1991:49

As indicated in Table 2.1, the vast majority of elderly people either live alone or with their spouses, as opposed to living with other relatives (such as their children) or with non relatives (for instance, in an institution or group home). However, the table also reveals important differences in the living arrangements of men and women. It is revealed that elderly men of ages from 66 -74 years and above are most likely to live with their spouses while the women of age 75 years and above also mostly live alone than living with spouse due to perhaps divorce or death of spouse due to relatively high age expectancy of women than men. This has been influenced by relatively high age expectancy of women than men as well as social security benefits which has been a measurable boost to their financial independence. Notwithstanding this social security benefits, the elderly women living alone are likely to be living in poverty. For instance, about 95 percent of the non-institutionalized elderly women who are poor, are living alone (Davis et al., 1990; Holden, 1988).

Physiologically, according to National Ageing Policy of Ghana (MESW, 2010), mobility of the elderly is sometimes restricted due to bodily weakness and inappropriate personal attendant to respond to the adequate needs of the aged. Lose of friends and spouse including relatives through death, rejection by relatives of the aged. Anderson (2002) observed that, increased in age without social network/contacts; increase the level of emotional stress as a result of loneliness. Ghana Statistical Service examined that, about 40.6 percent of the households in Ghana live in separate/semi-detached houses as a deviation from the traditional compound housing system. A situation which is gradually leading to a breakdown of the extended family system where family and/or household members sought support from the other. According to Schwab (1989), about 36 percent of the aged from 65 to 84 years live alone and only four percent live with their spouses and children, this therefore creates loneliness.

According to Anderson (2002), loneliness could be viewed from different basis; one of it being that loneliness is a reaction due to changes and/or lack of social relations which has been categorized into emotional and social loneliness. Emotional loneliness is the absence of intimacy while social loneliness is the absence of social relations. However, it is not always true that people who have a rich social or family network feels less lonely. Loneliness emerges when there is a perceived discrepancy between "ideal" and "real" levels of social interaction. If the social interaction is not as expected, needed or wished, then the person can experience loneliness. If ageing means that one is marginalized within a social network, it can cause a feeling of loneliness due to a discrepancy in contact compared with what existed before (MESW, 2010).

Some studies for example in United States have indicated that, elderly homeowners and residents or NORCs tend to be very satisfied not only with their living quarters, but also with the communities in which they live. For instance, a government study reported by Lewin and cited in New York Times (1991) revealed that, most of the older people live in neighbourhoods close to other family members which allow them to maintain social contact even if they live alone. Most of them have easy access to stores, banks, and other services they may need (Lewin, 1991).

Golant (1984) learned in his study of elderly residents in Evanston and Illinois that, a sizeable majority of older people take pride in their homes and neighbourhoods and associate both with pleasant memories. These elderly feel that, their homes are physically comfortable in

terms of size, temperature and attractiveness. Although Kendig (1990) advised that such findings should be interpreted cautiously, since many older people have low expectations with respect to housing standards. What was significant was how long they had lived in their homes and how satisfied they were with them.

Despite these positive assessments, home ownership for the elderly is not trouble-free. One of these situations is that, the elderly population previously was not much of a "problem" in the traditional societies of the developing world like Ghana. This was as a result of social ties and neighbourliness existed among the neighbourhoods. However, it has now become a major issue due to socio-economic pressures and rapid social change; the emerging nuclei family system is gradually disconnecting the traditional social connectivity which has seen to the increased of vulnerability of the aged such that, the elderly are being left to fend for themselves (UN, 1998; MESW, 2010). It is believed that old age is a period where expenditure increases while income decreases on the individual and nationally, demand for health, social services and social protection including housing and transportation increases. Some of the elderly are therefore more likely to live in poor, dilapidated and substandard housing and about 14 percent use outdoor toilet facilities (Kendig, 1990; MESW, 2010). With social contacts being a basic human need, a lack of it may affect the health of the aged in a negative way.

The prospect of a socially active life, autonomy/independence and to continue with hobbies are some of the most contributing factors to a high quality of life. It can add a positive self-image by keep on doing the things one has enjoyed in life. Autonomy and living at home will give increased valuation of life; however being dependant on others can add frustration and loss of spirit (Holmén, 2002). A major change in elderly peoples' lives was the passing of friends and relatives, as it had a great impact on their social network. With the loss of companionship they were more likely to stay in their own home (Gunnarsson, 2009).

This could be looked at both in the social and economic context. Social network has a strong impact on people's health and also the need for nursing care. Due to the fragile nature of the aged, including poor health status, and other socio-economic instabilities, their care ought to be professionally handled (with a team involving the sociologist, psychologist, physiologist, nurse and medical practitioner). It is a natural fact that the social network of the elderly people such as partner/relatives and friends diminishes due to death, immobility/ill-health and

or denial. Lack of social network is stress generating and may affect the social support and health of the elderly people (Reed, 2007; MESW, 2010). Study has shown that social support has beneficial effects on wellbeing of people especially the aged; it has a stress-buffering role (Hansson, 2009).

2.4.3 Health life of the Aged

Health has been described by many instances and through different perspectives. The World Health Organisation (2009) defined health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". Nursing theorist, Imogene King describes health as "dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living". Her view associates health to a continuous process which needs to be considered. It is a matter of *being* in health and not to *have* health (King, 1981).

The concept of health is important for nurses to help individuals achieve the goal of health. According to King (1981), "human beings function in a social system through interpersonal relationships in terms of their perceptions, which influence their life and health". To have control over one's daily life is an essential aspect in one's wellbeing and no lesser in the life of the elderly; this allows for self-realization and development and hence, the loss of control may lead to poorer quality of life and thus further leads to lower immunity.

According to Aaron Antonovsky's theory of autogenesis, those who have a strong sense of coherence have adequate generalized resistance resources which have a stress buffering function. A strong sense of coherence assists people to perceive life as comprehensive, manageable and meaningful (Antonovsky, 1987). A study on the subjective wellbeing of active elderly persons from the autogenic perspective indicated that strong sense of coherence creates or maintains a psychological integrity that has a positive effect on health (Weismann, 2008). A possible way to strengthen sense of coherence is to promote interventions strengthening autonomy (Suominen, 2008), a process where the elderly are able to influence and experience the purposefulness of their everyday life (Lindström, 2005).

Physiologically, it is evidence that, a greater incidence of acute and chronic sickness among the elderly affect their mobility than with the other age groups like the youth. Tinker reported that, averagely about 65 percent of aged, 75 years or over suffered from chronic health problems compare with averagely about 54 percent of the aged between 65 years and 74 years. It therefore shows that the main causes of loss of mobility among the elderly were the chronic diseases (arthritic and rheumatic conditions followed by cardiac and pulmonary conditions). These conditions affect the mobility of the elderly and aggravate their dependence. (Tinker 1984; MESW, 2010)

Again, another significance of the growing number of older people is that, they make the highest demands on health and personal social services (Tinker, 1984; MESW, 2010). For example, those who are over 75 years make even greater demands; and those over 85 years "particularly make heavy demands on the medical and social services"; meanwhile, according to the NDPC (2010), a greater proportion (over 88percent) of the Ghanaian population are in the informal sector which includes food crop agriculture and petty trading whose incomes are relatively low with little or no savings as social security, making them poorer in their old age. Notwithstanding, almost all chronic illnesses are age related, as their incidence increases with age (Binstock and George, 2001). This makes the socio-economic cost of ageing very unbearable to the aged. It is suggested therefore that decrease in mortality in these elderly adults is not just explained by conditions in early life but also by their present status and conditions (Catalano, 2002; Zimmer, 2006).

2.4.4 Financial /Income Support

The majority of senior citizens in United States are "aged in place". This means that most people 65 years and above continue to inhabit the dwellings they occupied while still in the labour force. This implies therefore that, the financial burden on the aged in US is reduced especially on the part of housing. Most of these houses they owned are located in the urban, middle class and working class neighbourhoods and suggests relatively improved environmental conditions. Almost 75 percent of the senior citizens live in urban areas (James, 1985). Kendig and US Department of Commerce (1990) reported that, about 75 percent of the aged 65 years and above in US, live in homes they own. According to analysts, the social security benefits have provided a measurable boost to the financial independence of senior citizen sover the years (Davis et al., 1990; Holden, 1988).

Peterson (1991) and Kendig (1990) also revealed that, about 85 percent of elderly homeowners have finished paying for their homes and are free of mortgage debt. This makes homes an important asset for most senior citizens. The tendency for most people to become "age in place" has given rise to what gerontologists called naturally occurring retirement communities (NORCs) (these are neighbourhood developments or entire towns or even just single apartment buildings that were not intended as residential areas for older people but where because of the population ageing, at least half of the residents are over 60 years old). According to researchers, more than 25 percent of the elderly in US live in naturally occurring retirement communities (Lewin, 1991).

According to A Report Card on the Housing Conditions and Needs of Older Americans updates, 1999, millions of elderly people live in housing that costs higher while about 6 percent of senior citizens (1.45 million households) live in housing that needs repair and/or rehabilitation and the worst housing conditions affects both homeowners and renters alike. Homeowners are much more likely to have the financial resources to address repair or rehabilitation needs. High costs are the most widespread housing problem among older Americans, with more than 7.4 million households paying more than they can afford. Thus, about 30 percent of elderly households have high housing costs, paying more than 30 percent of their income for shelter. Not surprisingly, affordability problems are highly concentrated among lower income households with few assets; approximately 1.7 million senior citizens with low incomes spend more than half their income on shelter. There is also a shortage of fully accessible housing in both the owner-occupied and the rental stock (American Housing Survey, 1997).

The report's final finding related to the appropriateness of housing for the elderly. Housing opportunities for seniors often remain fixed on the two extremes of the eldercare continuum-no assistance or nursing home care. In recent years both the private and public sectors have begun to respond to the need for alternatives to these two extremes. In answer to these challenges, according to the report, the Administration's Housing Security Plan is designed to help communities assemble and coordinate a comprehensive continuum of care to meet the changing housing and service needs of their elders. The plan embodies three overarching goals:

- Help senior citizens remain in their own homes.
- Expand affordable housing opportunities for low-income senior citizens.

- Improve the range and coordination of housing/service combinations

Long Term Care Insurance (LTCI), is another strategy by which Japan has adopted to reduce the financial burden of the social security fund. However, studies showed that the reduction due to LTCI was very limited and that the total health expenditures for the aged have increased by 0.30 percent more than expected. The rise in the use of institutional care is one of the main factors for this increase of expenditure. Before the introduction of LTCI, the access to nursing homes was strictly limited by the placement system. Formerly, as users had to pay users' fee according to the income-dependent sliding scale, users belonging to the middle and upper class had to pay almost all of the total cost. The introduction of LTCI has opened the door of nursing homes for all possible users regardless of their economic and social situation with 10 percent of co-payment. Now, the waiting list for institutional care under the LTCI scheme has become very long. The cost of institutional care is about 1.4 times more than home care, that is, in the case of care required, the amount of monthly benefit is about 225,000 yen (1875 US$) for a user in a nursing home, and 165,800 yen (1382 US$) for a user of home care. Therefore, an increase in the use of institutional care means an increase in the financial burden of the insurer. Thus, it is an urgent task for the government to develop high quality home care services and to facilitate the substitution from institutional to home care. Volume control at the local level, differentiation of user's fee (higher co-payment for the institutional care), and the introduction of cash allowance for home care service users will be possible solutions for limiting the volume of institutional services (American Housing Survey, 1997).

In the case of Ghana, according to GSS (2005) report, the effort by government and the society to reducing the impact of ageing on the elderly include the Social Security contributions and the "Cap 30" for pensioners. This is a deduction legally set aside by the employer from the employee's salary/wage as a social security towards the employee's retirement. However, this is sometimes not adequate to fully meet the aged needs. This is because, majority of these employee's incomes are low. There are still majority (over 80 percent) of the population who are either unemployed or in the informal sector/self employed and would not benefit from this social security.

There is also another effort reported by NDPC, (2006;2010) in taking care of the health needs of the aged in Ghana, and this is the national health insurance scheme where the aged at age

70 is exempted from the payment of premium. This however discriminate against the aged below 70 years, this age cohort (60-70 years) therefore has to struggle with health problems for the next 10 years after retirement from active service. Even, when one is able to crossover the mandatory age requirement of 70 years, there is another condition attached to the national health insurance scheme, where, certain ailments are not covered by this insurance scheme and therefore part of the cost of the healthcare delivery has to be borne by the aged. Research however shows that aged suffer/experience a diversity of diseases (MESW, 2010).

Again, there is this livelihood empowerment against poverty (LEAP) scheme which is implemented by the District/Municipal/Metropolitan Assemblies through the Department of Social Welfare. This seeks to give some incentives to the poor and vulnerable. However, the amount is not enough to cater for the needs of the aged. This scheme is also not focus on the aged specifically, rather, it is widely spread to cover all that has been classified as poor and vulnerable and the aged are sometimes not considered (MIPAA, 2007).

2.5 Issues from the National Aged Policy of Ghana

The 1994 International Conference on Population and Development (ICPD) identified issues of the elderly in society and called on governments to ensure greater equity for the aged, elimination of all forms of violence and discrimination against them and also strengthen formal and informal support systems and safety nets for elderly persons among others. By this, various policy frameworks including the African Union (AU) Policy Framework and Plan of Action on Ageing called for:

- Strengthening social protection schemes for elderly persons, particularly long-term care of the poor and frail;
- Recognizing and ensuring the provision of geriatric health care and supporting the care-giving services provided by older persons to grandchildren, orphans including those affected by HIV/AIDS and other disadvantaged young people;
- Eliminating violence and other crimes against older persons especially women;
- Promoting life-long education, training, healthy and active ageing;
- Providing assistance to meet the special needs of older persons who are caught up in conflict and other humanitarian/emergency situations; and
- Support gender-sensitive research on population ageing.

The Madrid International Plan of Action on Ageing (MIPAA) also called for changes in attitudes, policies and practices at all levels in all sectors so that the enormous potential of ageing in the twenty-first century will be fulfilled (MESW, 2010).

Clearly, the implications of ageing are vast and exert pressure on various services such as health, social services and social protection needs including housing, transportation and the agriculture due to the heavy demand of these services and the decrease in farm sizes as well as their participation in the sector due to old age. It is thus feared that, with the present projections in the increase in numbers of older persons, the economically active age groups will not be able to support the dependent age groups, who are mainly children and elderly but who were traditionally cared for by the family. Secondly, as an agricultural based economy, which depends so much on manpower, ageing could have a negative impact on economic growth due to the reduction in numbers and farm sizes with advancing age (MESW, 2010).

Incidence of disease and disability is believed to 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 on health, transport, housing and social services will be required to meet their specific needs most of which are usually expensive to obtain and maintain (MESW, 2010).

Despite the seemingly negative impact of ageing on the economy, it is also necessary to recognize that ageing have some positive influence on national development if properly planned.

Older persons in Ghana usually transfer knowledge, skill, experience, expertise and provide historical facts to the younger ones. The older persons traditionally act as mastercraftmen, handle arbitrations and settle disputes in the communities. This helps reduce the level of social unrest, civil strife and encourage community development. The field survey confirmed that the aged are regarded as fountain of knowledge and experiences to influence national development. In recognition of these and to harness their experiences, government institute appropriate policies and programmes that would provide support while utilizing the rich resource base of the older persons towards national development (MESW, 2010).

Demographic Dynamics

Available data indicates that the number of persons over 60years will increase from about 600 million in 2000 to almost 2billion in 2050. The fastest growing group of the older population is the oldest old (80 years or more). In 2000, the oldest old numbered 70 million and projected to increase to more than five times over the next 50 years. Another major demographic difference relates to gender, older women outnumber older men. The gender dimension of ageing must be a priority for global and national policy action. There are also rural and urban demographic differences in ageing. The population census of 2000 and other surveys on population indicate that the majority of people in Ghana (64 percent) live and work in rural areas where the greater proportion of older persons also resides (MESW, 2010).

It is also evident that, the aged in Ghana has been increasing over the years. The 2000 population and housing census report indicate that, the proportion of the elderly (65 years and above) formed 5.3 percent of the population, an increase from 4.0 percent in 1984. The percentage increase of the aged population between 1960 and 1970 was 12.5percent and increased to 32percent between 1984 and 2000. The ageing of the population is also reflected in the increase of the median age from 18.1 years in 1984 to 19.4 years in 2000. Another important issue of demographic concern is that the proportion of the elderly population in Ghana as a developing country is growing much more rapidly than those in the developed countries and among the highest in Africa. Such a demographic transformation has profound consequences for every aspect of individual, community, national and international life (MESW, 2010).

Ageing and the Development Challenge

In recent past older persons were accorded a high-ranking place in the traditional Ghanaian society but in the process of social change resulting from urbanization, migration and other global issues, traditional norms have been affected in several ways. These social transformations as well as poor infrastructure development in the rural areas have affected the patterns of social interactions and relationships in families and communities and consequently how they relate to older persons. Thus migration in all forms creates social distance and disengagement with a systematic reduction in certain forms of interactions with families. Older persons in Ghana are gradually showing signs of loneliness, poverty and neglect. The impact of this social neglect is felt the most, among older women. The females

are also overburdened with socio-cultural responsibilities and discrimination including the care of HIV/AIDS orphans and people leaving with AIDS (MESW, 2010).

It is also estimated that, about 60-80 percent of the working population in Ghana are engaged in subsistence farming and other informal work and therefore have no pension rights or any other form of reliable social security. Unfortunately, due to social transformation, economic constraints and high level of unemployment and under employment, the traditional expectation that the younger generation will take care of the old in time of need is no longer tenable. Older persons therefore can no longer rely on the traditional family support for survival. This is evidenced in the fact that, in many Ghanaian businesses older persons especially those in private and family businesses remain at work into advanced age for survival since there are no other sources of support if they should retire. Thus large numbers of both the urban and rural elderly persons work into their old age until they are physically unable to continue working. On the other hand, those who have the benefit of formal retirement benefits rather join the informal sector as soon as practicable, due to the inadequacy of their retirement benefits. This means that, many older persons in Ghana do not retire or have no peaceful retirement or leisure like their counterparts in the developed countries. Older persons must therefore be full participants in the development process and also share in its benefits. No individual should be denied the opportunity to benefit from development (MESW, 2010).

In Ghana, a high proportion of older persons are illiterate mainly due to poor access to education earlier in life. Formal education and training programmes limit older person's participation and thereby limit their access to new employment and other opportunities. As training and education programmes are developed, the skills and experience of older people are overlooked and their contributions are not encouraged. Several years of implementation of non-functional education programme in Ghana have not yet changed the situation necessitating some changes in policy and strategic orientation to non-functional education for older persons (MESW, 2010).

Ageing and Fundamental Human Rights

Research information and other reports revealed that fundamental rights of older persons such as the right to life and liberty, the right to work, and the right to freedom from discrimination

are often abused. Older people are abused by family and community members. They are sometimes accused of witchcraft and violently assaulted and tortured in some cases. Economically, they are discriminated against as financial institutions refuse them credit and other financial services. Their rights and needs are often overlooked by those implementing aid programmes and the contributions that older people can make are often ignored and their efforts undermined (MESW, 2010).

Ageing and Poverty

The Ghana Living Standards Survey (GLSS IV) on poverty profile estimated that 40 percent of Ghanaians are poor down from 51.7 percent in 1991-1992. This refers to citizens who have the capacity to meet their basic nutritional needs, but are unable to cater for additional necessities such as health, shelter, clothing, and education. It further estimated that, an additional 14.7 percent are afflicted by "extreme poverty" and further increased to 18.2 percent. Thus, unable to cater for basic human needs including their nutritional requirements and suffer from poverty across generations. As traditional family sources change, older people are no longer able to rely on the family for support. The situation often demands the use of social welfare programmes to pay the vital role of cushioning those who are most vulnerable (MESW, 2010).

Ghana's effort to decentralize social welfare delivery has not been backed with corresponding fiscal decentralization making the implementation of planned programmes ineffective. Older persons are often denied access to employment opportunities and are often the first to be targeted during periods of retrenchment. The ability to contribute and benefit from formal social security programmes is limited to those in the formal sector, and as a result most people enter old age without much social and income security. For those covered by social security systems, the values of their benefits are eroded by inflation and mismanagement thereby perpetuating poverty in old age. Older persons constitute a sizeable population of the poor in the country. The situation is worse amongst older women who face many barriers and discriminatory treatment during their lifetime. Poverty in old age is a result of many factors. Some of the notable ones include the following:

- Older persons are severely affected by adjustments in economic policies including retrenchment programmes - first to be targeted and hardest hit by cuts in social welfare programmes.

- Majority of older persons have worked and continue to work at the informal sector and have very limited incomes.
- Traditional forms of social security such as family and community support are weakening.
- Majority of the older person have not had the means or opportunity to contribute to pension schemes that would assist in old age. Gratuity, pension schemes and related entitlements only cover the few older persons who may have worked in the formal sector of the economy.
- Small scale farmers, fisher folks, craftsmen and petty traders do not benefit from these pension schemes.
- The benefits resulting from formal social security systems are in most cases inadequate and continuously lose their purchasing power with inflation
- Most people enter older age, poor after a life time of poverty.
- Poor health and nutritional status inhibit older persons' participation in income generating activities.
- Older persons often lack the skills to access employment opportunities and are usually denied opportunities to retrain. In most cases advertisements for jobs are discriminatory by specifying age and gender requirements
- Many older persons are caring for those affected by HIV/AIDS which depletes any existing resources and limits their involvement in income generating opportunities.
- Poverty alleviation programmes tend to discriminate against older persons.

Recent simulation and forecasting results show that it is possible for the government to halve the poverty incidence from 40 percent in 1999 to at least 21 percent by 2015 on condition that government will adopt policies that will enhance poverty reducing factors. It is imperative therefore to acknowledge that the poverty problem among older persons would be almost impossible 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 (MESW, 2010).

Health care challenges

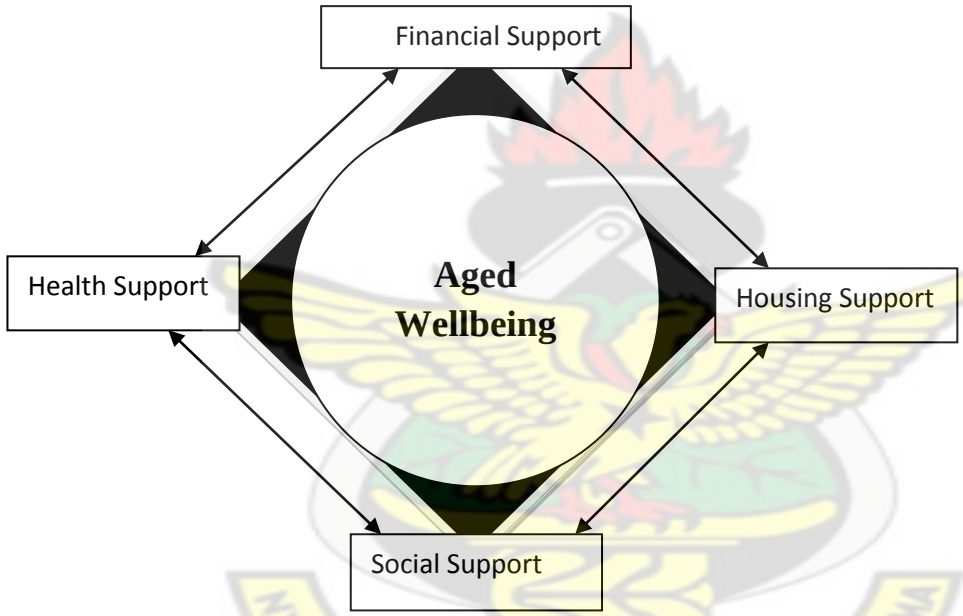
Good health is vital for economic growth and the development of societies. Older people's capacity to earn a living and participate in national development, community and family life

to a large extent depends on their state of health. 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 (MESW, 2010).

Conceptual Framework of the Aged Wellbeing

This is a framework or building blocks that summarises the ideas and processes of attaining the wellbeing of the aged including the research methodology processes as shown by Figure 2.1.

Figure 2.1: The "Four Cardinal Pillar" Concept of the Aged Wellbeing – A Conceptual Framework

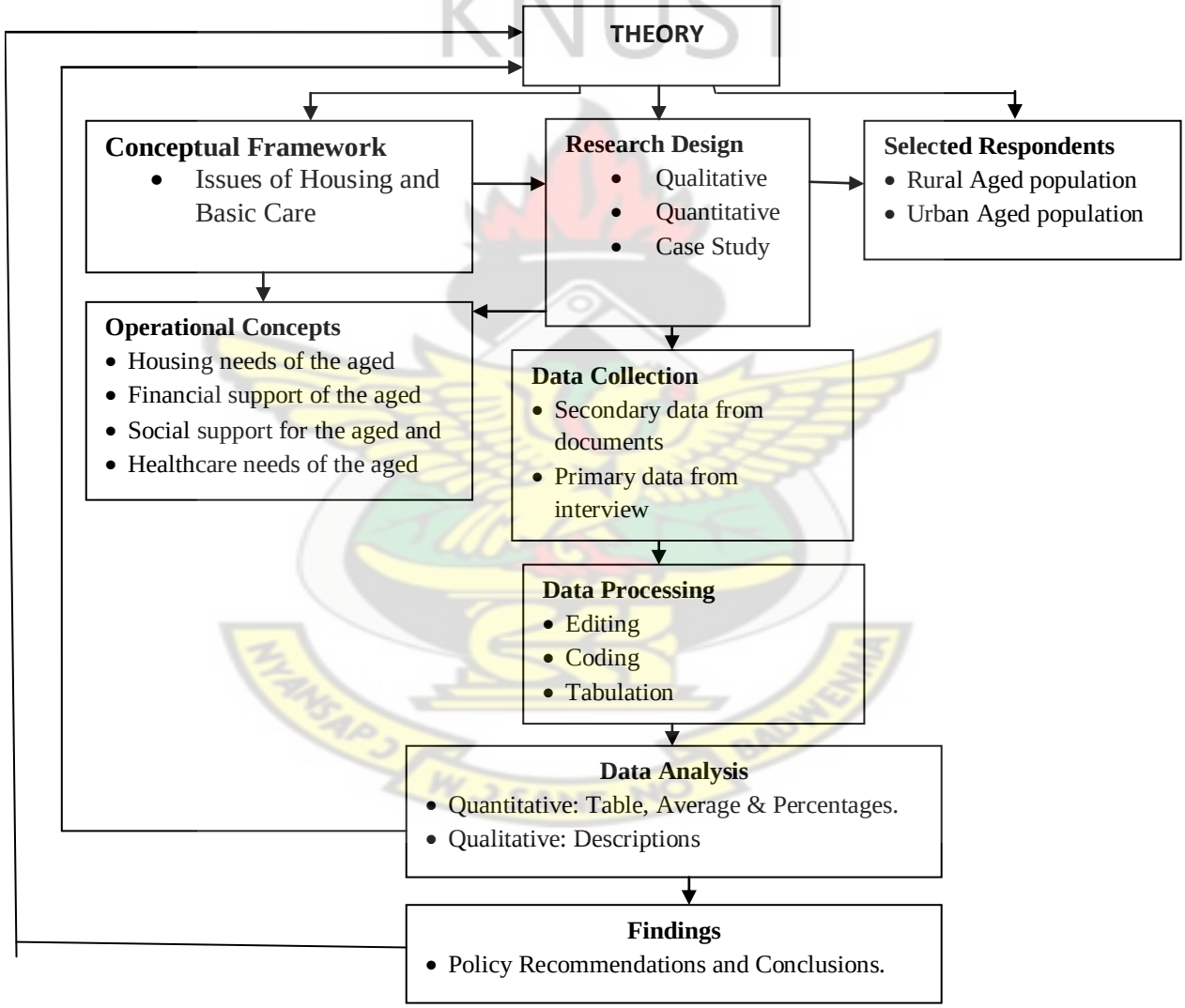


Author's Construct, May, 2011

This "four cardinal pillar" conceptual framework is cyclical in nature, and each of the points relates and supports each other harmoniously to ensure the wellbeing of the aged. These cardinal pillars include housing, healthcare, financial and social supports. The concept indicates that, a strong financial base of the aged is likely to make the aged be at ease and less stressful. This is likely to facilitate their access to adequate and suitable housing. Housing being both social and economic commodity would help improve the social life of the aged. As the socio-economic life of the aged improved, their health-life/condition would improve and social relationship is likely to be better. This has the tendency to reduce their stress because; they would have somebody to share their concerns and improved health conditions.

As their health situation improves through adequate access to healthcare and natural means (exercises and nutrition) and reduced stress, the cost in health would eventually be reduced. This implies that all the issues relating to the aged wellbeing have to be considered holistically with equal importance. Any attempt to down play or ignore any one of the issues would make the concept defective and the goal of aged wellbeing unachievable and worsened plight. This therefore calls for the deepening of the social welfare and primary healthcare concepts.

Figure 2.2: The Research Process – A Conceptual Framework



Source: Adapted from Babbie (2007)

From Figure 2.2, the theory behind the objective of the study, the extent to which the wellbeing of the aged has been incorporated into the national policy informed the choice of

quantitative and qualitative research design and a case study method. Again, the theory behind the objective of the study has influenced the conceptual framework of the effect of housing and basic care on the health of the aged as a major component of the literature review.

The figure also shows that the theory or objectives of the study and the case study method have informed the selection of the main respondents of the study incorporating both rural and urban setting into the investigation. Also, the conceptual framework and the case study method have determined the operational concepts or key variables for the study, including the housing and healthcare needs as well as financial and social support of the aged in the society and source of funding, policy direction and institutional role of the wellbeing of the aged.

Furthermore, the operational concepts or key variables for the study, the case study adopted and the main respondents of the study have influenced the choice of the collection of both secondary data from documents and primary data gathered mainly from interview.

Lastly, the figure indicates that these data collected have resulted in the data processing methods of editing, coding and tabulation. Both the quantitative and qualitative data is analyzed with the description of tables, charts, graphs and others. Findings were based on the analysis to make conclusions and policy recommendations to inform the theory.

2.6 Summary and Conclusion

Literature reviewed so far on the emerging problems of the aged has to a large extent attempted to identify the various issues such as housing, healthcare, financial and social support of the aged in the society. In analyzing these issues, various definitions and theories about ageing were clearly laid out. Various thoughts on these issues identified have to be subjected to scientific research to see how these issues influence the wellbeing of the aged.

Literature revealed that the main housing arrangements for the aged include renting, home ownership as well as homeless and slum. However, this has major financial and health implications for the aged. The other issue has to do with the health needs of the aged and this has shown that the aged are not well supported though they are susceptible to more chronic diseases than any other cohort. In terms of social support, due to cultural and social change

affected by economic factors, the aged suffer psychosocial and emotional stress as a result of loneliness and immobility. Financially, the aged incomes are low with little or no support even though, the cost of aged-hood is relatively high.

It could be deduced from the above literature that the aged is seen as a burden to the society and therefore little or no care is extended to them even at the national level hence there seem to be no comprehensive national policy to deal with the vulnerability of the aged in terms of housing, finance, health and social support though, it is a cohort everyone is aspiring to, willingly or otherwise.

Finally, all these issues collectively congregate to ensure the wellbeing of the aged. Ignoring anyone issue would not make the welfare of the aged be met.

CHAPTER THREE

PROFILE OF THE STUDY AREA AND RESEARCH METHODOLOGY

3.0 Introduction

A good research undoubtedly is influenced not only by the choice of appropriate methodology but also the right study/research area or location. This section therefore discusses the characteristics of the selected districts such as location and size, demography, economy and social services in relation to the aged wellbeing. It would also look at the right choice of methodology, this presents in detail the appropriate techniques and procedures employed to conduct the study. Its further explains the choice of research design, sources of data collection, method and instruments of data collection, the sampling techniques, key data variables and their measurement and the data processing, analysis as well as the reporting framework.

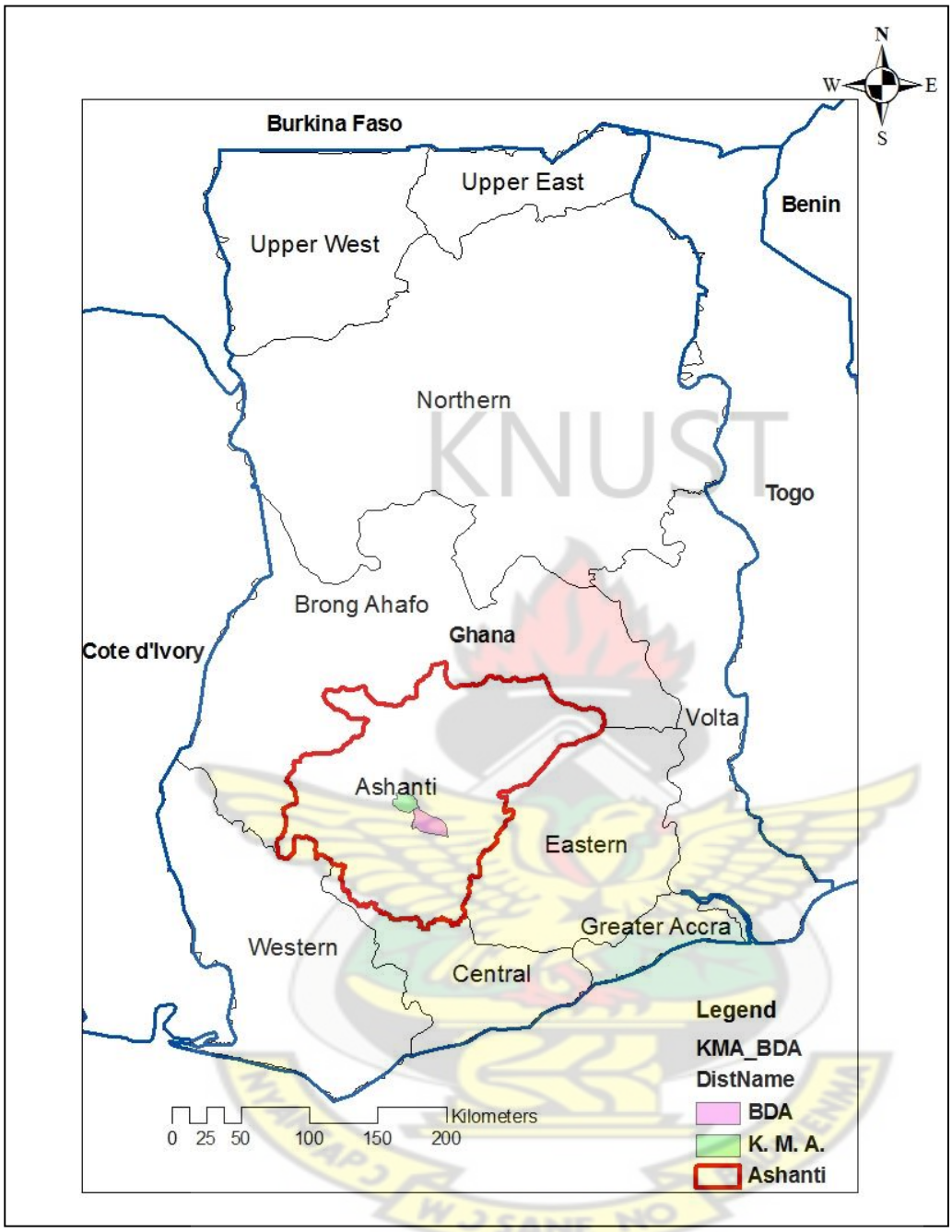
3.1 Geophysical Characteristics of Kumasi

3.1.1 Location and size

According to Kumasi Metropolitan Assembly (2010), Kumasi is located in the transitional forest zone, about 270km north of the national capital, Accra. It covers a total land area of 254 square kilometre and ranges between 250 – 300 metres above sea level. Kumasi is bounded to the north by Kwabre District, to the east by Ejisu Juabeng District, to the west by Atwima Nwabiagya District and to the south by Bosomtwe and Atwima Kwanwoma District.

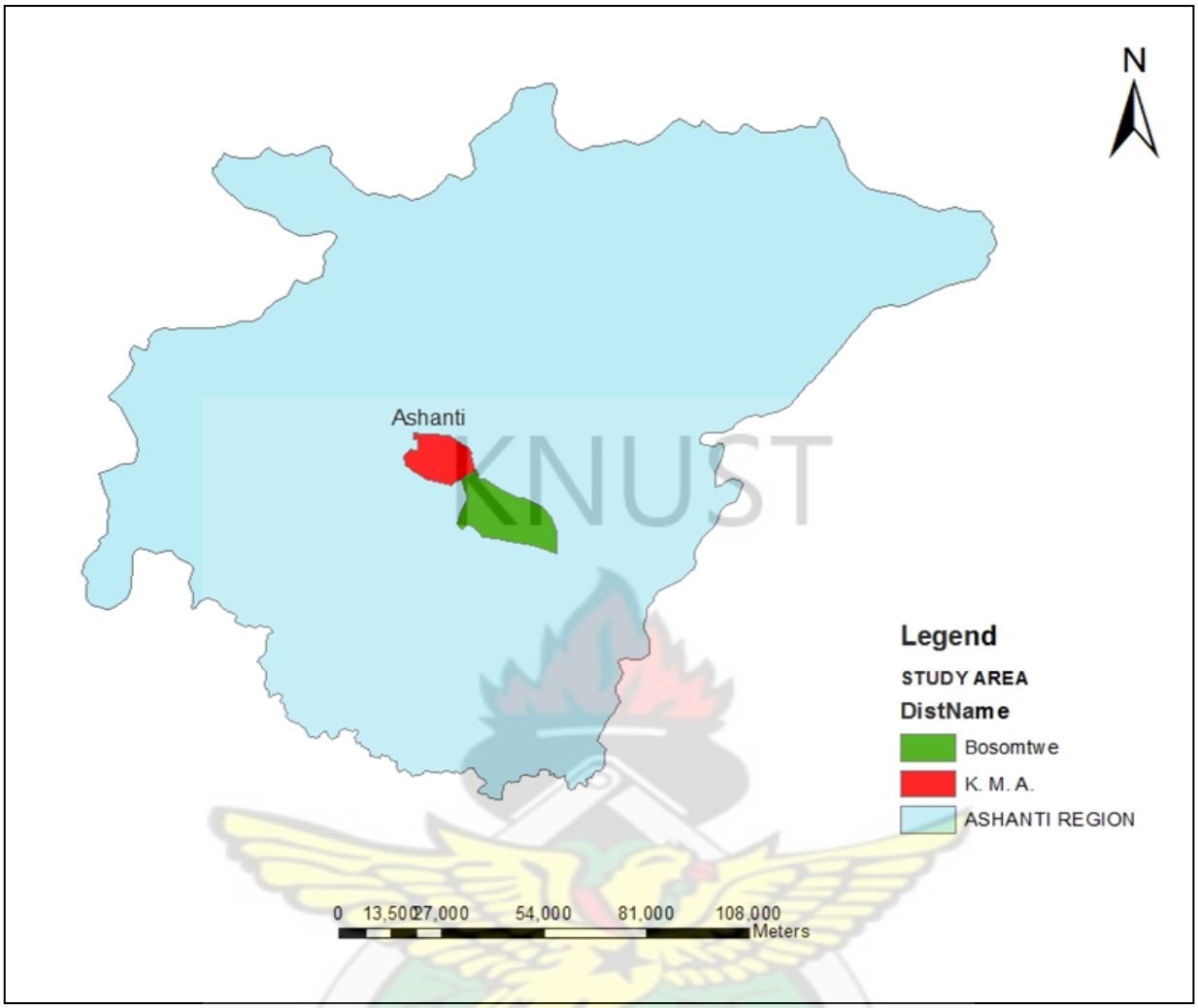
These districts are agrarian districts hence they serve as bread basket for the Metropolis. They also play important role in housing some of the active labour force that work in the Metropolis (estimated 400,000 commuters). The Metropolis, on the other hand, provides these districts with lucrative platform to market and sell their produce which contributes to revenue generation to these districts as well as Kumasi. It also houses facilities such as teaching hospital and universities which provides higher level services to the residents of these districts since they do not have the capacity to sustain the provision of such services. The unique centrality of Kumasi as a traversing point from all parts of the country also makes it a special place for many to migrate to. The administrative map of Ghana and Kumasi Metropolitan Area in the regional and national context is presented in Figure 3.1 and 3.2.

Figure 3.1: Map of Ashanti Region in National Context



Source: GIS, Ghana, May, 2011

Figure 3.2: Map of Kumasi Metropolis and Bosomtwi District in Ashanti Region



Source: GIS, Ghana, May, 2011

Population Characteristics

The Kumasi metropolis is the most populous district in the Ashanti Region. During the 2000 Population Census it recorded a figure of 1,170,270. It has been projected to have a population of 1,625,180 in 2006 based on a growth rate of 5.4 percent per annum and this accounts for just under a third (32.4 percent) of the region's population. Kumasi has attracted such a large population partly because it is the regional capital, and also the most commercialized centre in the region. Other reasons include the centrality of Kumasi as a nodal city with major arterial routes linking it to other parts of the country and also the fact that it is an educational centre with two State Universities, a Private University, a Polytechnic, two Teacher Training Colleges, Secondary Schools and a host of basic schools.

The growth of industries and the large volume of commercial activity in and around Kumasi as well as the high migrant number may account partly for the relatively high urban population. It has been estimated to have a daytime population of about 2 million. The population has grown rapidly over the inter-censal periods from 346,336 in 1970; 487,504 in 1984 to 1,170,270 in 2000. The census report estimated population growth rate as 5.47 percent. Table 3.1 shows Broad Age-Sex Structure of Kumasi.

Table 3.1: Broad Age – Sex Structure of Kumasi

Response / Age Group	Total Population		Male		Female	
	Absolute	**Percentage**	**Absolute**	**Percentage**	**Absolute**	**Percentage**
0-14	709,547.04	37	689,464.44	36	729683.2	38.1
15-64	1,104,998.3	57.7	1,105,058.3	57.4	1,110,803.8	58
65+	100,633.7	5.3	126,401.81	6.6	74,691.981	3.9

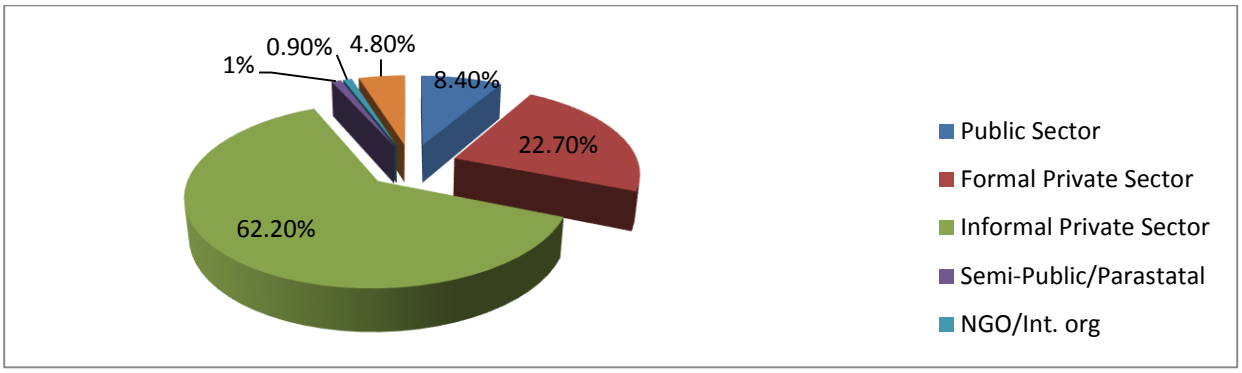
Source: GSS, 2005

The failure to match increase in population with housing supply has resulted in excess demand for housing accommodation. This phenomenon has given rise to exorbitant rental charges denying those who cannot afford a decent accommodation. This has led to the emergence of slums in the Metropolis, a phenomenon which is serving as breeding grounds for deviant behaviour.

Dependency Ratio and Occupation Distribution

The 2000 population and housing census results put the economically active population (between 15 and 64 years) at 57.7 percent and this could support development. This put the age dependency ratio for the Metropolis at 1:0.7. Therefore, propensity to save would have been relatively high but about 16 percent of the active population is unemployed reflecting economic dependency ratio of 1:1.1. About 62.2 percent of the population is in the informal private sector which most of them have low income indicating low capital formation for investment and low remittances to family members especially the aged as shown in Figure 3.3

Figure 3.3: Occupational Distribution of Kumasi Metropolitan Area



Source: KMA, 2002

The total land coverage of Kumasi Metropolitan Area is approximately 254sq. Km (25,415 hectares). Out of this 79.0 percent has been planned, approved and developed. The major land use that make up the metropolis are residential, commercial, industrial, educational, civic and culture, open spaces and circulation. Residential land use refers to the predominantly living areas in the metropolis and takes up 43.9 percent of the total land use of the metropolis.

Commercial activities in the metropolis take approximately 2.4 percent of the total land area and are mainly concentrated in the central area of the metropolis. However, these activities are now taking up new locations along the radial roads. Site for educational facilities take about 17.3 percent of the metropolitan area. Civic and cultural facilities occupy 7.3 percent of the total land area of the metropolis. It comprises locations for public and private offices, health delivery facilities, security establishments and centres for religious and social functions

Poverty Levels/Location

Poverty levels are generally perceived to be high in the metropolis. Even though the issue of poverty transcends the entire metropolis, it is more pronounced in the peri-urban and slum communities where facilities/opportunities are either inadequate or non-existent; poor housing, poor road network, absence of educational facilities, lack of access to quality health care, poor environmental sanitation, high illiteracy rates, relatively low incomes and high unemployment levels among others.

Religious Composition

The religious composition in the metropolis includes 78.8 percent Christians, 16 percent Islam, 0.3 percent Traditionalist and about 4.2 percent with no religious affiliation. The high percentage level of religious affiliation indicates an emotional and spiritual upliftment of the society especially the aged.

Household Size and Characteristics

The population of Kumasi is made up of 231,769 households and about 63.1 percent of the household population ranges from single-member households to four-member households. About 23.3 percent of the households are single-member while 39.8 percent are two – four member households with room occupancy rate of 2.7

3.2 Social Services

This section discusses housing, education and health which go a long way to support the wellbeing of the aged.

3.2.1 Housing

One of the basic needs of man is shelter. The component of social infrastructure that satisfies this need is housing. Housing is described as the dwelling unit and the infrastructural services that make a dwelling unit a home for households whiles a house is defined as the dwelling unit, the physical shed or a structure. Kumasi is a host to significant number and different kinds of housing facilities.

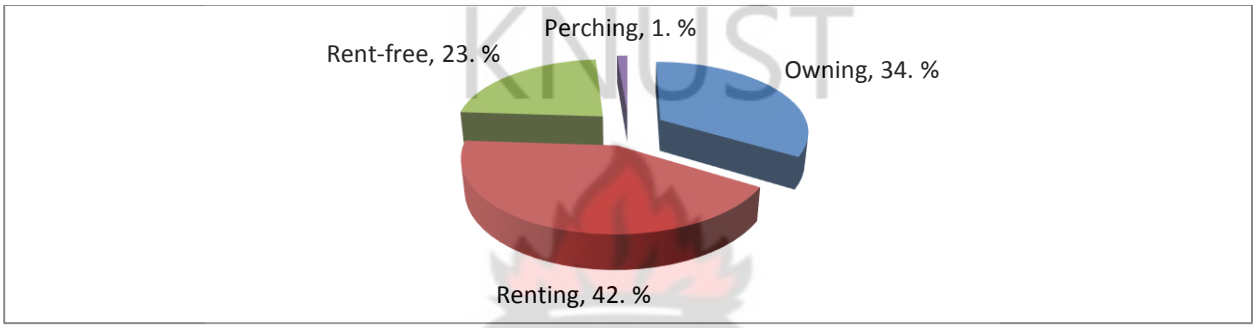
Housing Stock

The 2000 Population Census and Housing reports revealed that the housing stock in the Metropolis was 67,434, constituting 20.5 percent of the regional housing stock of 328,751. Growing at an annual rate of 2.4 percent, the housing stock in the Metropolis is projected to be 83,693 as of 2009. About 53 percent of the households in the Metropolis are housed by compound housing facilities with about 47 percent of them living in Separate Houses, Semi–Detached Houses, Flat/Apartment, Kiosk/Container and Others.

Housing Ownership/Tenure

Ownership of housing facilities in Kumasi is dominated by the private sector with 42 percent rented 23 percent rent-free and 34percent own their houses with one percent perching. Statistics available reveal that 97 percent of the households have access to potable water such as pipe-borne and borehole for drinking and carrying out other household chores. However, it has a challenge of intermittent irregular supply. The main source being Owabi head works, located 10km away from the CBD and Barekese head works, located 16km from the CBD.

Figure 3.4: Housing Tenure in Kumasi Metropolis



Source: KMA, 2002.

3.2.2 Health Services

It is the dream of every government that Ghanaians, whether poor or rich, rural or urban, have access to good healthcare, nutrition services and make healthcare affordable to ensure that citizens are healthy and productive. About189 health facilities with145 of them including pharmaceutical shops accredited with the National Insurance Scheme (both public and private) in Kumasi. Out of 993,762 patients who visited health facilities in Kumasi, 63.4 percent of them were insured clienteles of the NHIS. Kumasi metropolis has a doctor to population ratio of 1:41,606 compare to the doctor/population ratio of Ashanti Region and the nation (1:11,235 and 1:13,683 respectively). The nurse to population ratio however was 1:7,866, compare to nurse/population ratio of Ashanti Region and the national (1:2,465 and 1:1,451 respectively). This shows how pressure is exerted on the healthcare practitioners in Kumasi Metropolis.

3.2.3 Education

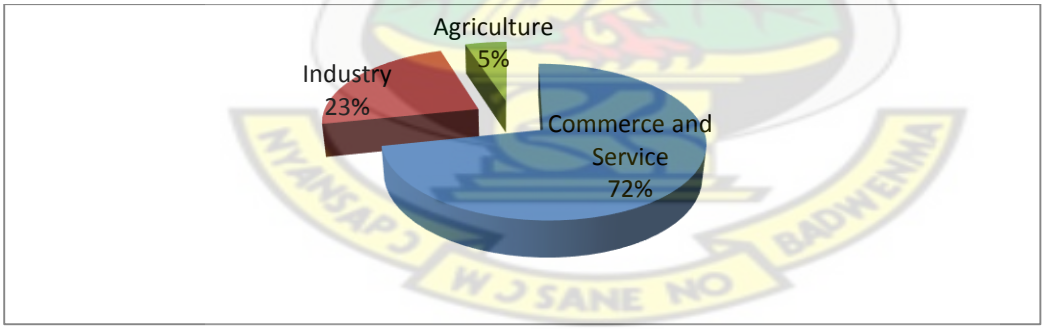
Skilled labour is needed in all sectors of the economy to promote development; education sector has become the sector mainly responsible in training human resource for development.

The total number of educational facilities in the Metropolis to support the provision of these services is 2,325 with 2238 of them being basic school, representing 96 percent of the total facility. The rest are 51 Senior High Schools, 24 Technical/Vocational Schools, four Special Schools, three Training Colleges and five being Tertiary education including Polytechnic. However, the private sector contributes about 71.2 percent of these facilities. The Pupil/Teacher Ratio for the Metropolis stand at 37:1 for Primary and18:1 for the Junior High School.

3.3 Local Economy

The economy of Kumasi Metropolis is driven by Service/Commerce employing about 72 percent of the economically active population with a wide range of products including financial institutions, telecommunications and trading. This is followed by Industry employing about 23 percent, significantly influenced by agglomerated small-scale mechanical garages, wood processing companies and food processing/bottling companies as well as construction firms. Agriculture however is in the subsistence level, mainly on vegetables and other food crops; it employs about 5 percent of the active labour force as shown in Figure. 3.5

Fig.3.5: Economic Structure of the Kumasi Metropolis



Source: KMA, 2002

Infrastructure

The metropolis is resourced with both social and economic infrastructure which includes potable water facilities, electricity and gas for both domestic and industrial use. However, there is the diversification of domestic energy use which includes, wood fuels/charcoal and kerosene for cooking and lightening.

3.4 Geophysical Characteristics of Bosomtwi District

Location and Size

According to Bosomtwi District Assembly (2010), the Bosomtwe District is located at the central part of the Ashanti Region. It lies within latitudes 6° 24 and 6° 43' North and 6°, 43' North and longitudes 1° 15' and West and 1° 46' West. It is bounded on the north by KMA, on the east by Ejisu-Juaben District, on the south by Bekwai Municipal and Bosome-Freho District, and on the west by Atwima-Kwanwoma District. It was curved out of formerly Bosomtwe Atwima-Kwanwoma District in 2008 by LI 1922. The district has a land size of about 500 sq km. The district has 65 communities with Kuntanase as its administrative capital. It is sub-divided by three area councils namely, Jachie, Kuntanase and Boneso.

Population Characteristics

According to the 2000 Population and Housing Census, the population of the District was 62,450 with 50.3 percent females and 49.7 percent males. Out of the 65 communities, only Jachie has population above 5000 (urban status), thus 7,368. About 90 percent of the communities are rural. Nearly 41 percent of the population falls in the 0-14 year group, 55 percent in the 15-64 year group and 4 percent fall in the 65 years and above age group.

Relief and Drainage

Apart from Lake Bosomtwi which has an outer ridge with a radius of about 10km and an elevation of 50 to 80 meters, the general topography of the district is undulating with a dendritic drainage pattern. Rivers and streams have a north-south direction of flow. However, there is a perennial internal drainage around the lake with streams flowing from the surrounding highlands. Notable rivers in the district include Oda, Butu, Siso, Supan and Adanbanwe.

Climate

The entire district falls within the equatorial climatic zone with two rainfall seasons. The major season begins from March to July and the minor from September to November. Usually August is a cool and dry but the main dry season occurs from December to March which coincides with the harmattan.

Temperature

There is a fair distribution of weather throughout the year with a mean temperature of 24°C. The highest average temperature of about 27.8°C occurs just before the rainy season in February.

Vegetation and Natural Resources

The vegetation of the entire district is the semi deciduous type of the forest. However, due to intensive and destructive logging/farming practices, the original thick forest has given way to secondary type making the main occupation, farming and other agricultural activities very difficult due to its impact on weather conditions in the area. The district is also underlain by Precambrian rocks of the Birimian and Tarkwaian formations associated with granites and metamorphosed sediments of phyllites and schilts. The district is endowed with some natural resources such as gold deposits, rocks, sand and stone deposits, clay deposits, forest resources. The only meteorite lake in West Africa, Lake Bosomtwe is also located in the district. However, it is shared with Bosome-FrehoDistrict.

3.5 Local Economy

The major occupation of the district is agriculture, employing about 62.6 percent of the entire population. The second employing sector is service/commerce, employing 19.1 percent of the population in the district. Industry employs about 16.7 percent of the population (Table 3.2).

Table 3.2: Major Occupation

SECTOR	PERCENTAGE (%)
Agriculture	62.6
Service	19.1
Industry	16.7
Others	1.6

Source: BDA, 2010

This shows that the district is more or less an agrarian economy mainly into cash crops, food crops and livestock. The cash crops include cocoa and palm oil; the food crops also include yam, plantain, maize, cocoyam and vegetables. Those into livestock also rear such animals as poultry, sheep, goat, cattle and pigs.

3.6 Social Services

This section discusses access to education and healthcare services in the Bosomtwi District.

Education

The District Education Office is the sole agency to implement and supervise educational policies in the District. The district has six circuits, 80 KGs, 85 Primary Schools, 57 Junior Secondary Schools and two Senior Secondary Schools. About 26,331, comprising 8,155 boys and 7,870 girls, pupils are enrolled in the basic schools. Teacher-Pupil Ratio is also in the range of 1:30. There are two senior high schools in the district with populations of 3,212, comprising 1,151 boys and 2,061 girls.

Health Service

The health delivery system in the district is carried by staff working in 16 public and private health institutions. These institutions are four government, seven CHAG or Mission and five private facilities. The district has 52 outreach points where Reproductive and child Services are rendered. One of the strongest strengths of the district is the Community Based Surveillance Volunteers (CBSVs) who have been trained to support community health services. They record and report on monthly bases diseases, deliveries and deaths in their various communities. Currently the district is running community TB care programme with the support of CBSVs. There are other non-orthodox spiritual and physical treatment centres in the district such as prayer camps herbal centres. There is currently collaboration between some of these centre's to embrace health service delivery. This has resulted from several advocacy sessions with some of these centre's to discuss health issues and other contributions as well as limitations.

Housing

The housing arrangement of the district comprises of individual owning, renting family own as well as perching. Over 60 percent live in family house, about 24 percent own their house, over 3 percent are renting and about 5 percent are perching. The buildings are made up of sandcrete and iron/aluminium sheets as roofing and these are in the majority. The rest are mud and straw while others are mud type but used cement for the finishing. The type of toilet facility used by these communities is KVIP and Pit latrine with about 80 percent using the public facility. Their main source of water is borehole with few communities using well. However, streams are used as alternative by most of the communities. With respect to energy,

firewood is the main source of energy for cooking, followed by charcoal. However, over 80 percent have access to electricity for lightening. This shows that these communities exhibit some kind of urban characteristics.

3.7 Summary of Profile

The above situational analysis has provided a vivid description of the characteristics of Kumasi Metropolis and Bosomtwi District (some of the important ancient tourist areas in Ghana and even beyond West Africa). The analysis took a cross-section of both the spatial and aspatial components of Kumasi and Bosomtwi and extracted the relevant information that borders on development and also related to the issues understudy. These were identified as development issues that call for comprehensive and concerted efforts by the authorities and relevant stakeholders to build consensus for national development.

3.8 Research Methodology

3.8.1 Research Design

Researchers, according to Patton (1990), have long debated the relative value of qualitative and quantitative inquiry. Qualitative research, broadly defined, means "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Strauss et al., 1990). Where quantitative researchers seek causal determination, prediction, and generalization of findings, qualitative researchers seek instead illumination, understanding and extrapolation to similar situations. Qualitative analysis results in a different type of knowledge than does quantitative inquiry.

Eisner (1991) pointed out that, all knowledge including that gained through quantitative research is referenced in qualities, and that there are many ways to represent the understanding of the world. There are other several considerations when deciding to adopt a qualitative research methodology. Strauss and Corbin (1990) claim that qualitative methods can be used to better understand any phenomenon about which little is yet known. They can also be used to gain new perspectives on things about which much is already known, or to gain more in-depth information that may be difficult to convey quantitatively. Thus, qualitative methods are appropriate in situations where one needs to first identify the

variables that might later be tested quantitatively, or where the researcher has determined that quantitative measures cannot adequately describe or interpret a situation. Research problems tend to be framed as open-ended questions that will support discovery of new information.

However, it is not necessary to juxtapose these two paradigms against one another in a competing stance. Patton (1990) advocates a "paradigm of choices" that seeks "*methodological appropriateness* as the primary criterion for judging methodological quality." This will allow for a "situational responsiveness" and not strict adherence to one paradigm or another. Furthermore, some researchers believe that qualitative and quantitative research can be effectively combined in the same research project (Strauss et al, 1990; Patton, 1990).

Quantitative and qualitative research has therefore been adopted as a research design for this study. This approach allows for the blending of both open-ended and close-ended questions in order to elicit more information from the aged, their caregivers and the other collaborative institutions. This qualitative research design is a non-experimental kind of approach which is concerned with the understanding of social phenomenon from the actor's perspective through participation and qualitative analysis (Cohen et al., 2007). Qualitative research however, according to Cohen et al. (2007), allows the researcher to employ ethnographic description of the process and makes the researcher to be immersed in the investigation. Notwithstanding, the adoption of this type of approach is appropriate for the study of the wellbeing of the aged.

A case study research method was used in this study. A case study involves an observation of a single group or event at a single point in time, usually subsequent to some phenomenon that allegedly produced change, such as an improved wellbeing of the aged after an intervention. Again, the case study permits in-depth investigation of the object using a variety of data gathering techniques to produce evidence that leads to understanding of the "case" and answers the research questions (Nachmias et al, 1992).

A case study method was adopted to carry out the research because the phenomenon under investigation is a contemporary one and the study is conducted within its real life situation. In addition, the case study brings the investigator and the case being investigated into direct contact. This leads to a better conversance with the circumstances of a case and helps to

assess the reactions of a group to questions and issues raised in the course of the investigation (Kumekpor, 2002).

Kumekpor, (2002), added that the case study is an explanatory method that enables the investigator to ask and seek answers to the "how" and "why" questions associated with the research. It also allows the investigator to pose questions, record intuitive hunches, testimonies, stories and illustrations from clients which can be used in later reports. The research approach or design depend on so many factors including control the researcher has over the problem under study, the focus of the research, rational, time and the type of data to be sourced. In the light of the aforementioned factors the case study was used.

The use of case study offered an empirical enquiry that allows the researcher investigates and understands the dynamics of the phenomenon under study, such as the issues of the aged in society. The strengths of this approach are that, it makes it possible to investigate contemporary phenomenon which has multiple realities and yet saddled with difficulties assessing the desired information (Nachmias et al, 1992). The approach made it possible to use the learning from the study to inform the theory and practice of policy formulation and planning in relation to the wellbeing of the aged.

In addition, the use of case study affords active and constructive research findings that can be applied to the issues being investigated. The choice of this approach was based on the fact that the study required multiple sources of evidence and the issue being investigated was contemporary over which the researcher had little control.

3.8.2 Data Requirement and Sources

The data required for this study includes the population of the aged who were facing the emerging problems of basic care and housing in the selected zonal/operational communities in the Kumasi Metropolis and Bosomtwi District Areas. In addition, data on the socio-economic characteristics of the aged such as their housing needs, means of financial support, access to social support and their health needs was required for the study.

Other data required for the study included national policy on the wellbeing of the aged in relation to their healthcare, financial and social support as well as their housing needs. The

role of these institutions as well as the contributions of the religious groups to support the care of the aged in ensuring their wellbeing was also required. These data was elicited from the Social Welfare Directorate, Compassionate African Aged Foundation, Orthodox Church, Pentecostal/Charismatic Church, Adventist Church and Islamic, and the District Assemblies. Table 3.3 indicates the key data sources of the study.

Table 3.3: Key Data Sources

Level	Data Source	Respondents	Data Required	Method of data Collection
Community	Aged groups	Aged(65+yr)	Financial and social support, health and housing needs.	Interview Guide
Community	Households	Caregivers of the aged	Financial and social support, health and housing needs.	Interview Guide
Region	CAAF	Regional Project Coordinator	Role on the care of the aged and available national aged policy.	Questionnaire Administration
District	Social Welfare	Director	Role on the care of the aged and available national aged policy.	Questionnaire Administration
District	DA	Planning Officer	Role on the care of the aged and available national aged policy.	Questionnaire Administration
District	Religious groupings	Leaders of the groups	Role on the care of the aged and available national aged policy.	Questionnaire Administration

Source: Field Survey, May, 2011

3.8.3 Data Collection Sources, Tools and Instruments

The study adopted a combination of both primary and secondary sources of data. The primary source was from the field survey; while the secondary sources of data included literature review on the topic involving a desk study to extract information from reports, newspapers, journals, articles, books, worldwide web (Internet) and any other source that was appropriate.

The data collection tools that were employed to conduct the research included direct observation, structured questionnaire and interview guide and (photographic) camera. The structured questionnaires were used for the collection of data on the activities of the institutions and the religious groups and assessed the availability of national policy on the care of the aged. Under this, a set of close and open ended questions was set and administered

to the heads of the Social Welfare Directorate, Regional Programmes Coordinator of Compassionate African Aged Foundation. Others included the local Head of Assemblies of God and Church of Pentecost, Methodist and Presbyterian Church, Anglican and Catholic Church, Islamic and Ahamadiya Muslim, Seventh Day Adventist and Adventist Reformed Church and the Planning Officers of Kumasi Metropolitan and Bosomtwi District Assemblies. These were purposively sampled.

In addition, a structured interview guide was used for eliciting information from the aged groups, 65 years and above and their caregivers. A pre-determined set of close-ended with some few open-ended questions was used for these respondents. This set of open-ended questions was used to elicit information on the challenges of the aged and any suggestions to remedy the situation. With listening, asking and probing questions, observations, and then interpreting questions to interviewees was used as data collection technique. The same wordings and sequence of questions as specified in the interview guide was used. This was done to make sure that any variations in responses can be attributed to the actual differences between the respondents and not to variations in the interview processes (Nachmias et al, 1992).

A direct and passive observation was also employed to collect data as evidence for the study. A visit was made to the meetings of these aged groups and observed, followed, recorded and took pictures of their activities during their meetings and assessed how their interactions helped to reduce boredom and stress as aged. This data collection instrument was chosen in the sense that where full or accurate information cannot be elicited from the respondents by questioning, direct observation is the best approach to collect the required data (Kumar, 1999). Anticipated challenges include the possibility of not acting naturally when the presence of the investigator was realized. The researcher may also forget some facts, if recorders (both audio and video) are not used or failed to function appropriately.

3.8.4 Key Data Variables for the Study and their Measurement

Variables are empirical property that takes two or more values. In order to move from the conceptual to the empirical level, concepts were converted into variables. It was with the variables that concepts eventually appeared in hypothesis and be tested (Nachmias et al,

1992). The key data variables for this research that have to be measured included the housing facilities, healthcare needs, financial and social support of the aged in the society.

In addition, the other key variables for the study included how the formulation of policies has been directed towards the wellbeing of the aged and the sources of financing their wellbeing and how have these policies affected the aged in the society.

Two measurement scales were employed to measure these variables. They were nominal and interval scales. The nominal scale was used to measure the socio-economic characteristics of the sampled aged groups. The properties of the objects of the variables to be measured were designated as identical to each other with each category assigned with a small bracket. The interval scale was used to measure the variables related to some indicators on their living standards and other levels. This scale gave the researcher the opportunity to use common and constant units to categorize these variables to make it easier for the respondents.

3.8.5 Sampling Design

A purposive sampling technique was used for the selection of the study area that is Ashanti Region due to proximity and cost effectiveness and also for the fact that, it is cosmopolitan and gives diversity of ethnicity. The selection of communities like Bomso, Oforikrom and Anloga in Kumasi Metropolis gives a purely urban/city setting while Apenkra, Kuntenase, and Jachie in Bosomtwi District also depict relatively a rural setting. These communities were purposively selected because; they exhibit most of the characteristics which is of interest to the study. Again, there is also a strong organized aged group in these communities which facilitates their easy access. This method was used because not every home may have an aged person if one wants to use other sampling methods like random or systematic.

Snowballing was used in locating the aged respondents. However, quota sampling was used to select the gender representation of the aged groups proportionately and based on their consent their caregivers were interviewed. The following religious institutions were purposively sampled and they were those which the aged respondents had some affiliation with. They are the Assemblies of God and Church of Pentecost, Methodist and Presbyterian Church, Anglican and Catholic Church, Islamic and Ahamadiya Muslim, Seventh Day Adventist and Adventist Reformed Church.

Table 3.4: Number of Aged in the Study Areas

District	Selected Community/Zone	No. of Aged Population		
		Male	Female	Total
Kumasi Metropolis	Bomso	48	53	101
	Oforikrom	64	96	160
	Anloga	54	70	124
Bosomtwi District	Jachie	61	89	150
	Kuntenase	52	73	125
	Apenkra	40	75	115
Total		**319**	**456**	**775**

Source: Compassionate African Aged Foundation, May 2011

The total number of the aged from the six selected communities which represents the sample frame was 775. Table 3.4 shows the sample frame of the aged population in the study area from which the sample size was calculated.

Sample Size Determination

The sample size was determined by a mathematical formula given by Miller and Brewer (2003) as; $n = \frac{N}{1 + N(\alpha)^2}$ where **N** is the sample frame, **n** is the sample size and $\boldsymbol{\alpha}$ is the margin of error (fixed at 5 percent).

The sample size, **n** becomes; n= {775/ [1+ 775(0.05) ^{2}]} = 775/2.937 = 263.87 = 264.

The aged who were interviewed were proportionally selected from the communities and per mathematical calculation (P x n/N) where "P" is population of the aged, "×" is multiplication sign, "N" is sample frame, "/" is division sign and "n" is sample size. The simple proportional formula which was used to calculate for the number of aged interviewed in each selected Community/zone were defined as follows; Sample Frame (SF) α Sample Size (SS); where α is a proportionality sign. The constant of proportionality then becomes the initial values of SS/SF. Calculation of the number of aged to be selected for interview from each community/zone refer to appendix E.

Table 3.5: Sample Frame and Sample Size of the Aged in the Study Area

District	Community /zone	Population	Sample Frame	Sample Size
		Aged	Aged	Aged
KMA	Bomso	101	101	34
	Oforikrom	160	160	55
	Anloga	124	124	42
Bosomtwi District	Jachie	150	400	51
	Kuntenase	125	125	43
	Apenkra	115	115	39
Total		**775**	**775**	**264**

Source: Field Survey, May 2011

Table 3.6: Total Number of Respondents in the Study Area

Interviewed Groups	Sample size
Aged	264
Caregivers	52
Planning Officers	2
Department of Social Welfare	2
Compassionate African Aged Foundation(CAAF)	1
Religious Groups (Muslim, Pentecostals, SDAs, Orthodox and Catholic Churches)	8
Total	**329**

Source: Field Survey, May, 2011

Data collection procedure

Before administering the questionnaires to the target population, pilot exercise was undertaken accidentally on three aged respondents, a Planning Officer from the Assembly, DSW Officer, a Religious leader and one caregiver for any necessary corrections and removal of ambiguities in the questionnaires.

3.8.6 Data Processing, Analysis and Reporting Framework

Data was processed and analyzed based on the understanding of the key concepts of the study, namely; the data collected was processed through editing, coding and tabulation. During the editing, the data collected was checked for their completeness, accuracy and uniformity. Deductive and inductive coding was used. With the deductive coding, the responses were classified into pre-established categories, as in the case with close-ended questions. With the inductive coding, the responses mentioned most frequently were included in a coding scheme to analyze the data (Nachmias et al, 1992). By way of tabulation, the data processed through editing and coding was transformed into tables and further summarized into frequencies, means and percentages.

Analysis of the data however was done using both quantitative and qualitative analytical techniques. The statistical package for the social sciences (SPSS) 2007version was used for these analysis based on descriptive, frequencies and multiple responses to arrive at these tables, charts, percentages and graphs for both the quantitative and qualitative analysis. The reason for the combination of the techniques ensured a credible and reliable generalization. Editing of the data was done with the aim of eliminating or minimizing errors for clean and reliable data.

Finally, conclusions were made in relation to the findings identified out of the analysis and policy recommendations were fashioned/ suggested.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.0 Introduction

This chapter presents analysis of the various issues that directly affect the wellbeing of the aged in Ghana, particularly in the Kumasi Metropolis and Bosomtwi District within Ashanti Region. This analysis discusses the socio-economic characteristics of the aged including the issues of their healthcare, housing, financial and social care. It would in addition discuss the role of caregivers as well as religious and other institutions in the wellbeing of the aged.

4.1 Socio-Economic Characteristics

This section analyses the characteristics of the respondents, their educational and marital statuses and how these influence the wellbeing of the aged in the society.

4.1.1 Characteristics of the Aged Respondents

A total of 264 aged were interviewed in six communities from two districts. One hundred and four representing 39.4 percent of them were males with 41.2 and 37.6 percent from urban and rural areas respectively. One hundred and sixty representing 60.6 percent females with 58.8 and 62.4 percent from the urban and rural areas respectively; this was based on proportional representation.

Table 4.1: Response by Gender

Community / Gender	Response [in Frequency (F) and Percentage(%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Male	54	41.2	50	37.6	104	39.4
Female	77	58.8	83	62.4	160	60.6
Total	131	100.0	133	100.0	264	100.0

Source: Field Survey, June, 2011

The ages of the aged respondents ranges between 65 and 100 years. The minimum household size was one and maximum size was seven (Table 4.1). This means that some have single household size or lives alone while others have larger household size. About 98.8 percent of

the respondents have between one and 22 children and only about 1.2 percent had no child. 25.4 percent of the aged respondents have a maximum of five children less than 18 years. It indicates a possible high cost of living due to high dependency rate as well as a possible receipt of remittances.

Table 4.2: Age Cohort of the Aged Respondents

Community / Age Cohort	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
65-69	37	28.2	38	28.6	75	28.4
70-74	38	29.1	37	27.8	75	28.4
75-79	22	16.8	26	19.5	48	18.2
80-84	15	11.5	24	18.1	39	14.7
85-89	18	13.8	3	2.3	21	7.9
90-94	1	0.8	2	1.5	3	1.1
95+	0	0	3	2.3	3	1.1
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

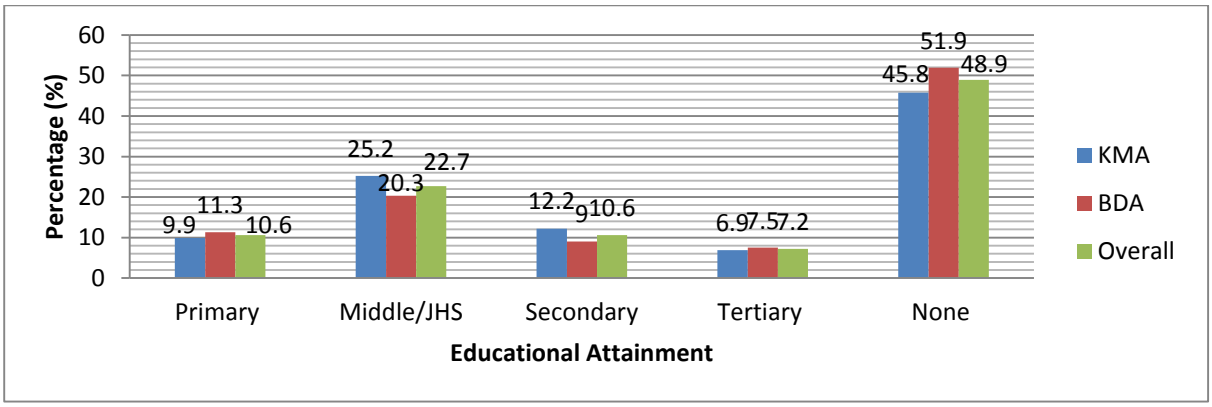
Source: Field Survey, June, 2011

Table 4.2 shows the age category of the respondents. It revealed that greater percentage (averagely 75 percent) of the aged is found between the age cohort of 65 and 79. Therefore any policy that seeks to exclude these age cohorts would cut off the greater percentage the aged population. Again, the 65-69 age cohorts represent an average of 28.4 percent of the aged population and therefore, averagely 28.4 percent of the aged population are denied of free payment of the national health insurance scheme premium.

4.1.2 Educational Status/Level of Aged Respondents

Education allows an individual to gain access to better economic opportunities, earn a good salary and enhances his/her socio-economic conditions even after retirement. As ones income is higher, his/her standard of living relatively improves and all things being equal, he/she is able to save more to take care of his/her aged needs better than the one whose incomes are low and largely depends on that low income (NDPC, 2010).

Figure 4.1 Educational Status/Levels of Aged Respondents



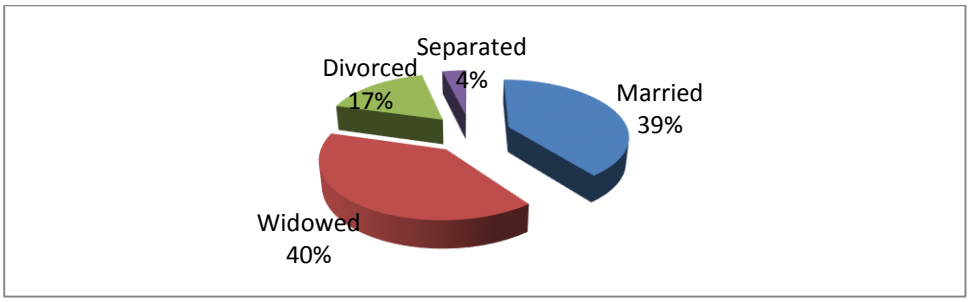
Source: Field Survey, June, 2011

Fig. 4.1 indicates that 51.9 percent of the aged in the rural communities as against 45.8 percent in the urban communities have not had formal education before, representing an average of 48.9 percent. This is lower than 2006 gross enrolment rate of 84.3 percent (World Bank, 2007). On tertiary education however, those in the rural communities are slightly more than those in the urban communities (7.5 percent as against 6.9 percent). This could perhaps, be attributed to those who have returned to live in the villages after formally retiring from active employment. More aged in the urban communities had formal education for both the basic and secondary school levels than those in the rural communities (i.e. 25.2 and 12.2 percent as against 20.3 and 9.0 percent) respectively. This implies that relatively, more aged people in the urban communities have better standard of living than those in the rural communities.

4.1.3 Marital Status of the Aged Respondents

Emotional support as a form of social support generally comes from family and close friends and is the most commonly recognized form of social support. It includes empathy, concern, caring, love, and trust (House, 1981).Marriage as a union between two people; help create some form of social interaction which enhances the social life of the couple. People who are not married and live alone are less likely to receive social support than people who are married or cohabitate. This help to improve the health life of the aged, poor social support is associated with mental health problems, such as depression (Dalgard et al., 1995).

Figure 4.2: Marital Status of the Aged Respondents



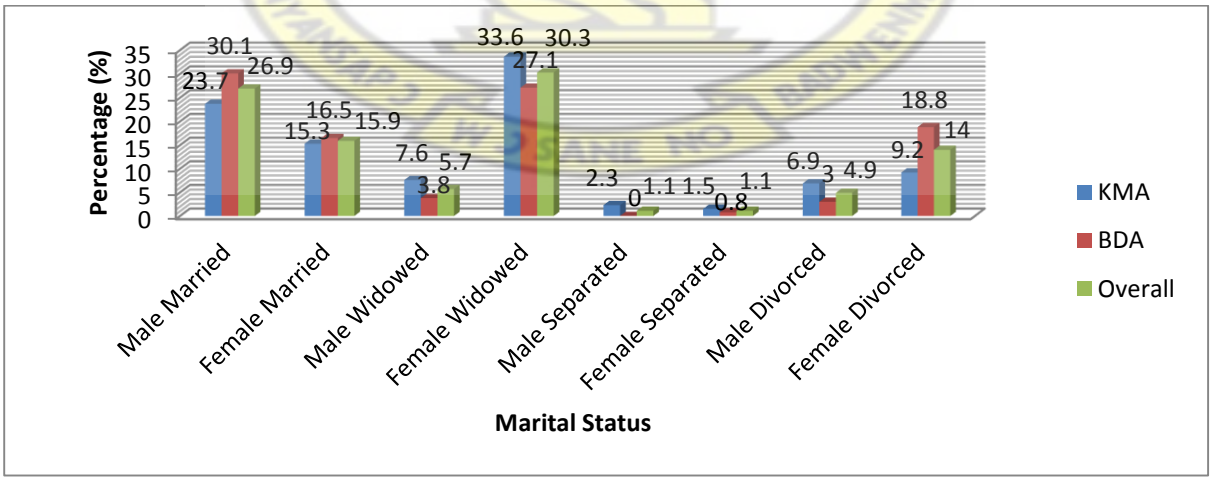
Source: Field Survey, June, 2011

From Figure 4.2, about 40 percent of the aged are widowed, 39 percent are married, 17 percent have divorced and four (4) percent have separated. This shows that about 61 percent of the aged are either not living with their spouses or have no spouse and therefore may not enjoy enough social interaction. Only 39 percent are married or living with their spouse at old age. The implication therefore is that, the majority (61 percent) of the aged may lack emotional support which is received from spouses and this could affect their health life.

4.1.4: Marital Status by Gender

Apart from looking at marital issues generally, it is also ideal to analyse it in gender perspective by comparing which of the gender and or at what location, rural or urban is more vulnerable. The study revealed that, averagely 30.3 percent of the aged females were widows as compare to 5.7 percent of males.

Figure 4.3: Marital Status by Gender



Source: Field Survey, June, 2011

In terms of specific communities, 27.1 percent of the females as compare to 3.8 percent of the males in the rural communities were widows. While 33.6 percent as against 7.6 percent of the

males in the urban areas were also widows. Again, it was revealed by Figure 4.3that, an average of 26.9 percent of the males compare to 15.9 percent of the females was living with their spouses. The implication is that, the majority of the females may suffer emotionally as compare to the males because; the males relatively stay in marriage longer than the females and therefore enjoy more emotional support than the aged females. The aged in the rural areas were also more likely to marry longer than the urban areas and therefore may enjoy relative emotional stability than those in the urban areas which would result to better health conditions due to adequate socialization.

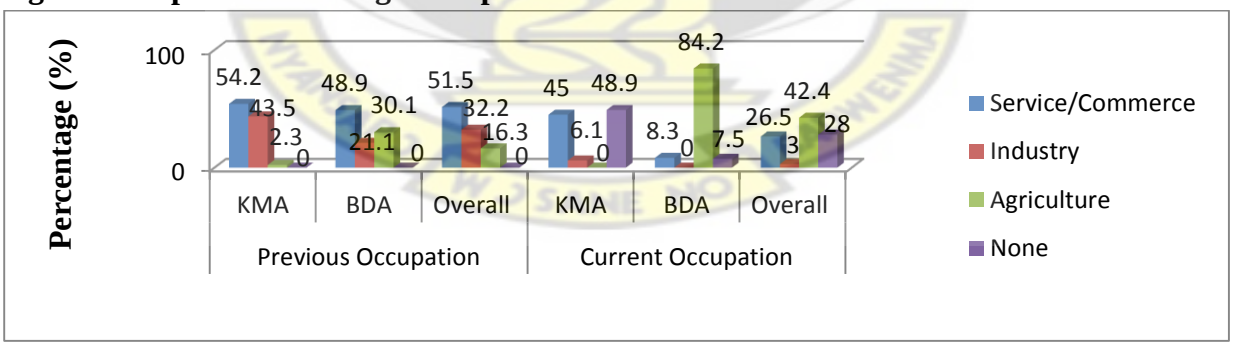
4.2 Financial Situation of the Aged

This section assesses the following, the occupation of the aged respondents, their sources of income, expenditure as well as the income and expenditure analysis of the aged, number of times the aged respondents eats in a day and diet restrictions of the aged.

4.2.1 Occupation of the Aged Respondents

Employment is a basic but very important aspect of every adult's life and also a basis of human development, without which individual development would be in jeopardy and the national economy would not as well be spared. However, it is up to the individual legally or socially to retire from active service after 60 years, according to the national pensions Act. Such employee should have made some contributions towards his/her retirement.

Fig 4.4 Occupation of the Aged Respondents



Source: Field Survey, June. 2011

The study identified two categories of occupation, the previous and current occupation (i.e. before and after retirement jobs respectively). It was revealed in the previous occupation that, majority of the people were employed in the service/commerce sector in both the urban and rural communities (54.2 and 48.9percent) respectively. For the urban areas agriculture was

the least offered employment (2.3 percent) while industry was the least (21.1 percent) for the rural areas. With the current occupation however, agriculture employed the highest (84.2 percent) in the rural areas. In the urban areas however, service/commerce sector employed 45 percent of the aged. Agriculture and industry offered no employment to the aged in the urban and rural areas respectively.

The average sectoral employment for the previous occupation was dominated by service/commerce (51.5 percent) followed by industry (32.2 percent) and the least was agriculture at 16.3 percent. The current occupation on the other hand, agriculture employed the highest (42.4 percent), service/commerce sector employed 26.5 percent and industry was the least (3 percent). Those without employment were the second highest (28 percent). The implication is that those without employment depend either on their investments or remittances or other sources for living which any hiccup would cause disaster for them. This has been graphically explained in Figure 4.4.

4.2.2 Sources of Income of the Aged

The financial situation of the aged in these study areas are not far from these indicators/ definitions. The study revealed two main sources of income of the aged; the sustained and unsustained incomes. The sustained/reliable incomes are the incomes which the beneficiary has power over its source and this include amount from present occupation/current employment, rent on property, pension as well as other investments. The unsustained/unreliable incomes on the other hand, the beneficiary has no power over its source and it includes remittances from children and other relatives, LEAP Fund, as well as the Church and other philanthropic institutions support.

Table 4.3: Sources of Monthly Household Income

Response / Source	Frequency (%)	Minimum Income (Gh¢)	Maximum Income (Gh¢)	Mean/Average Income (Gh¢)
Children	91.30	5.00	300.00	75.16
Relatives	9.10	10.00	100.00	55.83
Current Employment	5.70	20.00	100.00	47.67
Pension	22.30	45.00	300.00	139.42
Rent Property	3.80	5.00	175.00	64.80
Investment	4.90	20.00	100.00	45.92
LEAP Fund	1.10	24.00	30.00	26.00
Church	7.90	10.00	200.00	76.52

Source: Field Survey, June, 2011

The study revealed that out of the 264 aged respondents, 241 representing 91.3 percent depend on remittances at an average or mean income of 75.16 Ghana Cedis (ranges between 5.00 and 300.00 Ghana Cedis) per month from their children as either supplement or main income. Only 59 aged respondents, representing 22.3 percent received a mean income of 139.42 Ghana Cedis from pension (ranges between 45.00 as minimum and 300.00 as maximum Ghana Cedis) income, while 7.9 percent were supported by the religious institutions at a mean income of 76.52 Ghana Cedis (ranges between 10.00 and 200.00 Ghana Cedis).

The other sources of income include, 4.9 percent on other investments, 3.8 percent received from rent on property the least been LEAP fund which is only 1.1 percent ranges between 24.00 and 30.00 Ghana Cedis or a mean income of 26.00 Ghana Cedis as indicated in the Table 4.3.The study further revealed that, those who received income from pension, besides having stable income, also have relatively high income which ranges between 45.00 and 300.00 Ghana Cedis with a mean income of 139.42 Ghana Cedis representing about 26 percent of the total mean income of the aged.

4.2.3 Expenditure of the Aged

Rationally, every person would spend in relation to his/her income, though, economic principle has it that wants are insatiable; hence scale of preference cannot be discounted in this situation.

Table 4.4: Monthly Household Expenditure

Expenditure / Source	Frequency (%)	Minimum (Gh¢)	Maximum (Gh¢)	Mean/Average (Gh¢)
Food	100.0	30.00	300.00	137.84
Clothing	14.0	2.00	12.00	5.40
Housing/Rent	41.7	2.00	20.00	8.55
Water	78.0	2.00	50.00	3.97
Electricity	98.8	2.00	70.00	5.85
Transport	81.4	1.00	20.00	4.21
Church/Funeral	90.9	2.00	30.00	6.81
Healthcare	100.0	2.00	45.00	6.02

Source: Field Survey, June, 2011

The various essential things that the household or an individual aged in the study area spent their incomes on included food, clothing and accommodation. The rest are utilities including water and electricity, transport, Church/funeral and on healthcare. From Table 4.4, the study revealed that the average household expenditure on food is 137.84 Ghana Cedis, (ranges between GH¢ 30.00 and 300.00) depending on the size of the household. This represents 77.4 percent of the total average expenditure and all (100 percent) the aged made some spending on this commodity. The next item they spend their sizeable income on is accommodation at a mean expenditure of 8.55 Ghana Cedis (ranges between GH¢ 2.00 and 20.00) representing 4.8 percent of the average expenditure with 41.7 percent of the aged respondents spends on. Expenditure on water was the lowest of all; the mean expenditure is 3.97 Ghana Cedis (ranges from GH¢2.00 and 50.00) per month with 78 percent of the aged spend on. About 98.8 percent of the aged spend on electricity at a mean monthly expenditure of 5.85 Ghana Cedis (ranges between GH¢2.00 and 70.00).

It was also revealed that, all (100 percent) the aged spend on healthcare at a mean monthly expenditure of 6.02 Ghana Cedis (ranges from GH₵2.00 to 45.00).This implies that, food and healthcare were the two most important as well as basic necessities of life of the aged, where all of them spend on. It also means that the entire aged respondents, accesses healthcare and this can be attributed to the existence of the National Health Insurance Scheme where almost all of them have access to. However, the 6.02 Ghana Cedis cost of the average expenditure that goes into healthcare are still burdensome to some of the aged who resort to self medication.

4.2.4 Income and Expenditure Analysis of the Aged

Income and expenditure analysis could be one of the simplified means of determining or measuring the welfare of an individual or a group of people. It shows at a glance how much an individual or a group is earning at a particular point in time as against how much that individual or group is spending or using the income earned at that same period. The difference/gap shows whether there is a surplus or deficit and that measures the welfare of that individual or group.

Table 4.5: Average Income/Expenditure Analysis of the Aged

Monthly Measurement / Monthly Average	**Household Average Income**	**Household Average Expenditure**	**Difference**
Average Frequency	18.3	75.6	57.3
Average Minimum	17.40	5.40	12.0
Average Maximum	63.10	68.40	-5.3

Source: Field Survey, June, 2011

From table 4.5, an average of 18.3 percent of the Aged earn an average minimum income of about 17 Ghana Cedis and average maximum income of about 63 Ghana Cedis with average mean income of about 66 Ghana Cedis. It was also revealed that, an average of 75.6 percent of the Aged spend an average minimum of 5.40 Ghana Cedis and average maximum of about 68 Ghana Cedis. In relation to income and expenditure analysis, about 57 percent makes a surplus of 12 Ghana Cedis on their minimum expenditure and a deficit of about five Ghana Cedis on the maximum expenditure. Notwithstanding some surpluses, their incomes are far

below the World Bank's/MDG recommended minimum income of about one dollar per head per day representing a monthly income of about thirty dollars per head, equivalent to sixty Ghana Cedis per head per month. It therefore implies that the people are relatively poor because their monthly average income is less than the UN recommended dollar related income of an individual.

4.2.5 Number of Times the Aged Eats in a Day

Food has been described as a necessary component of human survival, without which the body system would not function properly, especially with the aged (Dalgard, 2009). For this reason, the study looked at the eaten pattern of the aged. According to the study averagely, about 38.6 percent of the respondents ate twice a day whilst 61 percent ate thrice a day and only 0.4 percent ate once a day (Table 4.6). This implies, more than half of the aged population met the "three-square meals a day" requirement slogan, but the quality and quantity of the food in terms of its nutritional value and satisfaction needs much to be desired.

Table 4.6: Number of Times the Aged Respondent Eats Daily

Community / **Response**	**Response [Frequency (F) Percentage (%)]**					
	KMA		**BDA**		**Overall**	
	F	**%**	**F**	**%**	**F**	**%**
Once	0	0	1	0.8	1	0.4
Twice	59	45.0	43	32.3	102	38.6
Thrice	72	55.0	89	66.9	161	61.0
Total	131	100.0	133	100.0	264	100.0

Source: Field Survey, June, 2011

4.2.6 Diet Restrictions of the Aged

About 96.2 percent of the aged had no diet restrictions while 3.8 percent of the aged had restrictions on their diet (Table 4.7). This means that, the greater percentage of the aged may not be suffering from chronic diseases such as hypertension or diabetes which demand for diet restriction. This however, depends on how they heeded to the advice of their medical consultants.

Table 4.7: Diet Restriction of the Aged Respondent

Community / Response	Response [Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Yes	3	2.3	7	5.3	10	3.8
No	128	97.7	126	94.7	254	96.2
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

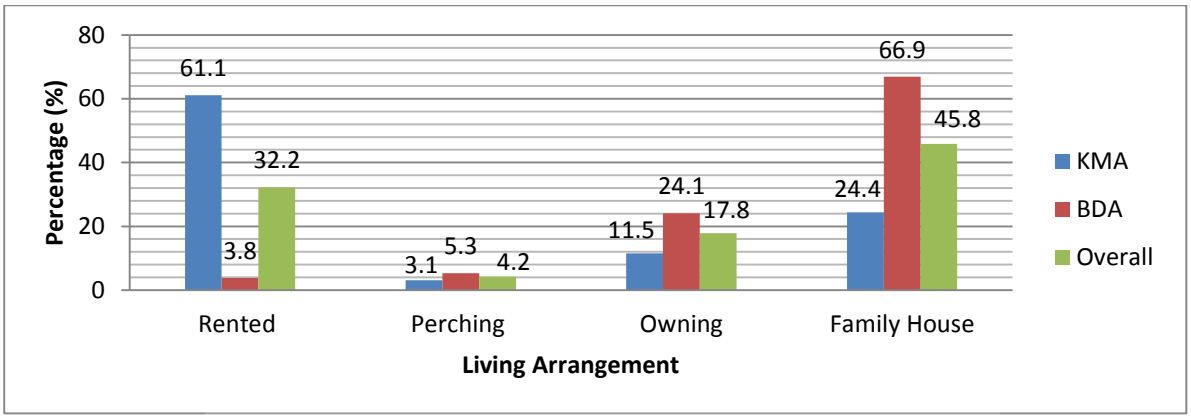
4.3 The Housing Situation of the Aged

According to WHO (2011), housing conditions are likely to affect people's health situation including the aged. Inadequate housing causes or contributes to other preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. Poor design or construction of homes is the cause of most home accidents. In some European countries for instance, poor design kills more people than do road accidents. The use of proper building materials and construction could prevent indoor pollutants or mould which could cause asthma, allergies or respiratory diseases. This section therefore discusses the following, the kind of living arrangement, type of toilet facility used, place of accessing the toilet facility, source of water for consumption, sources of energy for cooking and lightening.

4.3.1 Kind of Living Arrangement

The study revealed that, the aged population had the various options of accommodation; this includes renting, perching, owning and family housing. Averagely, 45.8 percent of the aged lived in family house, 32.2 percent were in rented housing, 17.8 percent owned their house and 4.2 percent were perching shown in Figure 4.5. Comparatively, this Figure is lower than the KMA figure where 42 percent rented and 34 percent own their houses but higher than the 2005 national average of 11.2 percent.

Figure 4.5: Kind of Living Arrangement



Source: Field Survey, June, 2011

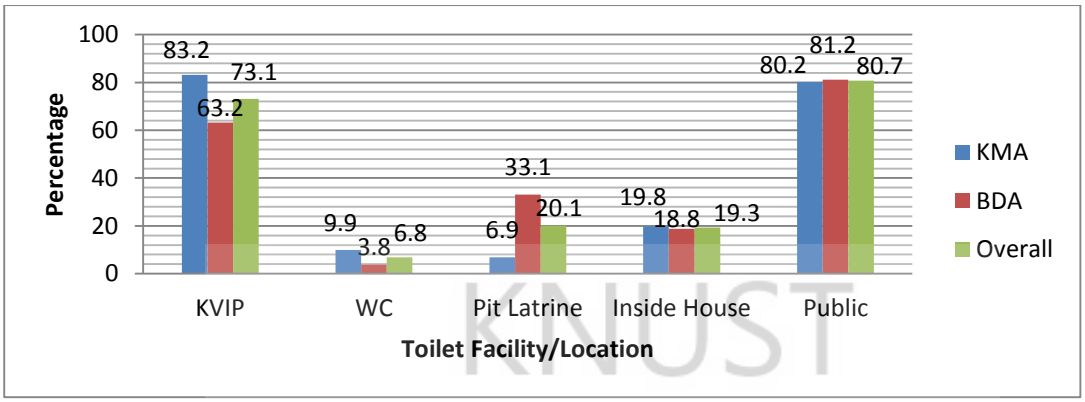
The research indicated again that 66.9 percent who lived in their family house, were from the rural areas while 24.4 percent from the urban areas. Those renting a house were 61.1 percent and lived in the urban areas while 3.8 percent were from the rural areas. Those owning a house, according to the study, 24.1 percent were from the rural areas and 11.5 percent were from the urban areas. This implies the majority of the aged who owned their house are from the rural areas. It also indicates that the cost of living in the rural areas is relatively lower than the urban areas. Having 66.9 percent of the aged lived in their family house in the rural areas also implies that, the family ties that exited among the rural communities are stronger than that of the urban communities which are more cosmopolitan than the rural areas. Averagely, only 17.8 percent of the aged owned a house implies that, the majority of the aged are in the relative low income bracket and also a declined of the 2002 KMA report of 34 percent. However, the average rented of 32.2 percent was lower than the national average of 43 percent.

4.3.2 Type of Toilet Facility and Place to Access it

In most of the Ghanaian communities, the kind of toilet facility a household used could be used to assess the socio-economic status of that household in the society. It is perceived that, when a household uses water closet (WC) it implies, that household has higher standard of living and has direct relationship with sanitation. Apart from relating it to sanitation and status, it could also have to do with the comfort use of the facility. Some of the aged usually have a number of health challenges and more often than not it has to do with joint pains including waist and knee. This suggests that they would have problems in squatting. This therefore would call for sitting as a comfortable means of "visiting the toilet". A tailor-made

toilet facility to suit the need of the aged population in the society would be the appropriate toilet facility for the aged.

Figure 4.6: Type of Toilet Facility Used and Where to Access the Facility



Source: Field Survey, June, 2011

The study revealed that, 83.2 percent of the aged from the urban communities used KVIP, 6.9 percent used Pit Latrine and only 9.9 percent used WC as presented in Figure 4.6. In the rural communities, on the other hand, 63.2 percent used KVIP, 33.1 percent used Pit latrine and only 3.8 percent used WC. Averagely, 73.1 percent used KVIP, 20.1 percent used Pit latrine and only 6.8 percent used WC toilet facility. The study again revealed that, 80.2 and 81.2 percent of the urban and rural areas respectively access the facility from the public/outside the house while 19.8 and 18.8 percent of the urban and rural communities respectively access the facility inside the house. Averagely, 80.7 percent access it from the public and only 19.3 percent access it from inside the house. On a whole, the research indicated that all the respondents have access to toilet facility and expected that they would use them accordingly other than open defecation unless on special reasons and this is higher than the 2008 national average of 11 percent (NDPC, 2010). Notwithstanding, about 73 and 80 percent using KVIP and accessing it outside their homes respectively implies, majority of the aged relatively have low standard of living and are more exposed to poor sanitation and poor health condition. They would therefore need much support to improve their lot.

4.3.3 Source of Water Consumption

Quality of water for consumption can said to be an important necessity for human health. For this reason, the researcher sought to find out the sources of water the aged population depends on for consumption.

Table 4.8: Source of Water for Consumption

Community / Response	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Pipe-borne	125	95.4	24	18.0	149	56.4
Borehole	2	1.5	87	65.4	89	33.7
Well	4	3.1	22	16.5	26	9.8
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

From Table 4.8, an average of 56.4 percent of the aged respondents has access to pipe-borne water, 33.7 percent have access to borehole water and 9.8 percent have access to well water. About 95percentof the aged from the urban areas as against 18 percent in the rural areas have access to pipe-borne water, 1.5 percent from the urban areas as compare to 65.4 percent from the rural areas uses borehole water, while 3.1 percent and 16.5 percent in the urban and rural communities respectively used well water. The analysis indicated that, generally about 90percent of the aged have access to relatively potable water (pipe-borne and borehole) and about ten percent uses well. Stream was an alternative source; however, the people did not depend on it. Comparatively, access to relatively potable water is higher than the 2009 national coverage of 57.5percent access. This therefore implies that, majority of the aged may not be at risk of water related diseases particularly in the study area.

4.3.4 Sources of Energy for Cooking

The kind of energy one uses has more often than not been related to access in terms of availability and affordability of that source or the income of that individual. Averagely, 51.5 percent of the aged population relied on charcoal for cooking while about 38 percent also rely on firewood for cooking. Only 6.4 percent and 3.8 percent depend on gas and electricity respectively for cooking.

Table 4.9: Sources of Energy for Cooking

Response / Community	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Charcoal	107	81.7	29	21.8	136	51.5
Electricity	9	6.9	1	0.8	10	3.8
Gas	11	8.4	6	4.5	17	6.4
Fire wood	4	3.1	97	72.9	101	38.3
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

It was also shown from able 4.9 that, 81.7percent of the aged in the urban areas and 21.8 percent from the rural areas depended on charcoal for cooking. Another 3.1 percent and 72.9 percent of the aged from the urban and rural communities respectively depended on firewood for cooking. However, only few (6.9 and 0.8 percent from the urban and rural areas respectively) depended on electricity while 8.4 and 4.5 percent from both urban and rural areas respectively depended on gas for cooking. This implies that as high as 84.8 from the urban and 94.7 percent from the rural areas or averagely 89.8 percent depended on both charcoal and firewood for cooking and this is higher than the 2009 national average of 63 percent (NDPC, 2010). Only 15.3 percent and 5.3 percent from the urban and rural communities respectively depended on gas and electricity for cooking though an average of over 84 percent have access to electricity. This could lead to environmental abuse promoting desertification, and this does not promote development.

4.3.5 Sources of Energy for Lightening

Energy for lightening is another essential facility for every household. Apart from it being used for maintaining illumination at night, others also used it in addition to keep warmth. The study revealed that, averagely, 84.5 percent of the aged used electricity and only 11 percent used lantern and 4.5 percent used other sources (such as candle light, "bobo light", fire and no light).

Table 4.10: Sources of Energy for Lightening

Community / Response	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Lantern	16	12.2	13	9.8	29	11.0
Electricity	109	83.2	114	85.7	223	84.5
Others	6	4.6	6	4.5	12	4.5
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

It was also revealed that 83.2 percent and 85.7 percent in both urban and rural communities respectively used electricity. Only 12.2 percent and 9.8 percent in the urban and rural communities respectively used lantern as indicated in Table 4.10. This implies, averagely majority (about 84.5 percent) of the aged have access to electricity which is higher than the 2009 national average of 66 percent household access to electricity(NDPC, 2010) and this has the tendency to support development.

4.4 The Level of Social Support to the Aged

Cobb, (1976) cited by Dalgard, defined social support generally as help in difficult life situations. Social support is a concept that is generally understood in an intuitive sense as, the help from other people in a difficult life situation. One of the first definitions put forward by Cobbas 'the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations'. Among the things that the study will discuss includes social care by the caregiver, contractual agreement with the caregiver, means of breaking boredom by the aged.

4.4.1 The Caregiver (Direct Social Care) of the Aged

According to this study, the caregivers play a vital role in the life of the aged population. They provide psychosocial and physiological assistance to the elderly such as engaging the aged in conversation to reduce their stress level which could otherwise aggravated their relatively poor health conditions. They again support the aged to move about easily with little difficulty. They also run the errands of these aged groups while others in addition to all that,

help them to do their house chores and other necessary activities. The absence of these caregivers might not only create uncomfortable situation for the elderly but could also facilitate and accelerate their early pass-off into eternity.

Table 4.11: The Caregiver (Direct Social Care) of the Aged

Community / Response	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Spouse	48	36.6	47	35.3	95	36.0
Children	54	41.2	46	34.6	100	37.9
Grandchildren/Other Relative	27	20.2	34	25.6	61	22.9
Others	3	2.0	6	4.5	8	3.2
Total	**131**	**100. 0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

The study revealed that, averagely 37.9 percent of the aged population was staying with their children with 36 percent staying with their spouses. Indicating that, majority of the aged, relatively felt more comfortable and secured socially for living with either their spouses or children. However, 22.9 percent stayed with their grandchildren or other relatives while 3.2 percent stayed either alone or with a hired caregiver. The study also revealed that, relatively more aged in the urban communities lived with their children (41.2 percent) and spouses (36.6 percent) than those in the rural communities (34.6 and 35.3 percent) respectively. Relatively, majority of the aged in the rural communities (25.6 percent) than those in the urban (20.2percent) lived with their grandchildren/other relatives. Only 2.0 and 4.5 percent in the urban and rural areas respectively have other source of living arrangement such as hired caregivers as indicated in Table 4.11. This could be due to rural-urban migration where most of the able bodied persons left for the urban centres or elsewhere for "greener pastures" leaving their aged parents in the care of their children/other relatives and/or hired caregivers. The study however exposed the fact that hired care-giving is not a common practice culturally as compare to the other one's discussed above. This does not promote development because it could negatively affect productivity of the care-givers.

4.4.2 Contractual Agreement with Caregivers

It could be deduced from the study that hiring or contracting caregivers to take care of the aged family members seemed not be a tradition or culture of the Ghanaian society. People prefer staying with their own aged family members or bringing their close family members to stay with them rather than hired caregivers without considering the consequences it might have on their job or their children's education.

Table 4.12: Contractual Agreement with the Aged

Community / Response	Response [in Frequency (f) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Yes	3	2.3	4	3.0	7	2.7
No	128	97.7	129	97.0	257	97.3
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

It is shown from Table 4.12 that averagely, as high as 97.3 percent did not accept having contractual agreement with their caregivers. This reflected both in the urban (97.7 percent) and rural (97 percent) communities. Only 2.3 in the urban and 3 percent from the rural areas have some sort of contractual agreement with their caregivers. This implies that the people took care of their own aged family members and this has possibility of affecting their daily activities and in the long run affecting development.

4.4.3 Means of Breaking Boredom

This sought to find out what the aged respondent usually or regularly do with the view of keeping him/herself active to reducing stress and unhappiness. It does not necessarily mean that he/she would not do any other thing.

Table 4.13: Means of Breaking Boredom

Community / Response	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Visit Friends	66	50.4	58	43.6	124	47.0
Join Club/Associations	2	1.5	2	1.5	4	1.5
Move About	33	25.2	28	21.1	61	23.1
Attend Church	14	10.7	14	10.5	28	10.6
Others	16	12.2	31	23.3	47	17.8
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

The research revealed that averagely, 47 percent of the aged visits friends to break boredom whereas 23.1 percent move or walk about which also helped kept their bodies fit as a by-product of breaking boredom. About 10.6 percent also used regular church attendance while 17.8 percent used either the combination of some of the mentioned means of breaking boredom or reading and or watching television as a means of reducing boredom. The study again showed that, 50.4 percent from the urban areas as against 43.6 percent from the rural areas used visitation as a means of breaking boredom (Table 4.13). About 25.2 percent as against 21.1 percent of the urban and rural communities respectively move about to reduce boredom. Again, 10.7 percent and 10.5 percent from urban and rural areas respectively used church/fellowship attendance as a means of reducing boredom. Only 1.5 percent from both urban and rural areas join club/association to reduce their boredom. About 12.2 percent and 23.3 percent from urban and rural communities respectively used other means such as watching television, reading of books, listening to the radio as well as sleeping as a means of breaking boredom. This implies that majority of the aged used visitation of friends to break boredom and in the process reduces their stress level. This has the tendency of improving their health situation for national development.

4.5 The Healthcare Situation of the Aged

The ultimate goal of health under the GPRS II is to ensure a healthy and productive population capable of contributing to socio-economic development and wealth creation in the country. For this reason the NHIS policy is being implemented which seeks to increase

access to healthcare with a reduced cost and in addition exempted those in 70 years and above from premium payment (NDPC, 2006; 2010).This section therefore discusses the following, type of health facility mostly visited, reason for choosing that health care, means of payment, type of illness mostly reported, means of sustaining health and physical impairment of the aged.

4.5.1: Type of Health Facility Mostly Visited By the Aged

Many people have their reason for visiting a particular health facility especially where there are options to choose from. The study revealed that, averagely 93.6 percent preferred hospital/clinic which is higher than the 2009 national average of hospital attendance (NDPC, 2010).About 2.3 percent used herbal/traditional method while 4.2 percent also used other means such as spiritual belief and natural therapy/exercises.

Table 4.14: Type of Health Facility Visited by the Aged

Community / Facility	Response [in Frequency and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Hospital/Clinic	122	93.4	125	93.7	247	93.6
Herbal	2	1.6	4	3.0	6	2.3
Others	7	5.1	4	3.3	11	4.2
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, 2011

Table 4.14 revealed that 93.4 percent of the aged from the urban areas as against 93.7 percent from the rural areas used hospital/clinic, 1.6 percent compare to 3 percent from the urban and rural communities respectively used herbal/traditional method. Those using other methods such as spiritual beliefs and or natural therapy/exercises, 5.1 percent were from urban areas and 3.3 percent from rural areas. The implication is that, the majority of the aged from both the urban and rural areas used hospital/clinic or orthodox means of healthcare. Comparatively however, the majority (93.7 percent) of the aged from the rural areas other than those from the urban areas (1.6 percent) used herbal/traditional method of healthcare. The basic reason of majority using orthodox means other than herbal or unorthodox means of healthcare according to the aged respondents is the operations of the NHIS in most of the hospitals/clinics. However, there is an average of 6.5 percent who still relied on the herbal as

well as spiritual and other means of healthcare in view of the unfriendly nature of the hospitals. This includes long waiting time, cost of healthcare even in the face of NHIS as well as routine nature of medical care.

4.5.2Reason for Choosing that Health Facility

Every individual of the aged had their own reason of choosing or selecting a particular health facility. The study revealed that averagely, 71.6 percent based their choice on better service which includes availability and access to quality medical officer, laboratory and medicine. About 8percent saw cost of accessing the medical services as very necessary. In human society, no matter what is done some people would still remain indifferent. In this wise, about18.9 percent had no specific reason or not sure of selecting the type of health facility they chose, they therefore chose as and when it suits them.

Table 4.15: Reason for Choosing that Health Care

Community / Choice	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Better Service	103	78.6	86	64.7	189	71.6
Good Proximity	0	0	4	3.0	4	1.5
Affordable	11	8.4	10	7.5	21	8.0
No Reason/Not Sure	17	13.0	33	24.8	50	18.9
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

Table 4.15 indicated further that 78.6 percent and 64.7 percent from urban and rural communities respectively based their choice on better service. Also, 8.4 and 7.5 percent from the urban and rural areas accordingly based their selection on the cost of healthcare while as high as 13 percent from the urban and 24.8 percent from the rural areas are indifferent as to what health facility to choose. This implies that more people prefer better healthcare services and as long as it eludes them, they would always go for self-medication or unorthodox means of healthcare. This could be the reason why a large number of people remained indifferent as to the facility to choose and hop from one health facility to the other to seek medical care without recourse to their health/medical history. Hence, the NHIS faces some difficulty and

complaint of an abuse by some of the beneficiaries. This has led to the implementation of the health capitation system.

4.5.3 Means of Paying For Health Care

Having rationally chosen a health facility, there is the need to meet the cost of accessing the services of that facility. The study indicated that, there were two major means by which the people met the cost of service to their healthcare and these were either health insurance or individual own payment. However, it became necessary that, those with health insurance sometimes paid for certain services in addition to their health insurance. This was because not all the services including medications are covered by the insurance. As shown in Table 4.16, averagely 86.7 percent of the aged have access to health insurance while 13.3 percent were without health insurance. Comparatively, 86.2 percent of the urban and 87.2 percent of the rural communities have access to health insurance. However, 13.7 and 12.8 percent of the urban and rural communities had not registered for health insurance due to inadequate income.

Table 4.16: Means of Paying for Health Care

Community / Means	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Without Health Insurance	18	13.7	17	12.8	35	13.3
With Health Insurance	113	86.2	116	87.2	229	86.7
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

This implies that, the majority (86.7 percent) of the aged used health insurance to access healthcare this is higher than the 2009 national average of about 62 percent (NDPC, 2010). only few (13.3 percent) of the aged were without access to health insurance and these may either use cash to access healthcare or avoid orthodox means of healthcare due to inadequate finances. These vulnerable may be resorting to spiritual and psychological or self-medication. However, those with health insurance complained of using cash in addition to access healthcare. This is because, certain services and medications were not covered by the health insurance and this could be a motivating factor of the aged resulting to self-medication or unorthodox means of accessing healthcare.

4.5.4 Type of Illness Mostly Reported to Health Facility

Tinker in 1984 reported that the aged population is vulnerable/prone to illness and most of them usually have not less than one illness. The research indicated that averagely, 58percent of the aged reported of more than one illness, 24.3percent regularly reports bodily/joint pains which emanated from tiredness and weakness in the body as a result of old age. It was 5.7 percent that reported heart related diseases. About 2.3 percent had problem with their eyesight while as low as 1.1 percent were suffering from rheumatism.

Table 4.17: Illness Mostly Reported to Health Facility

Community / Illness Type	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Diabetes	1	0.8	3	2.3	4	1.5
Rheumatism	2	1.5	1	0.8	3	1.1
Heart Related Diseases	6	4.6	9	6.8	15	5.7
Stroke	4	2.8	1	1.0	5	1.9
Eye Sight	1	0.8	5	3.8	6	2.3
Bodily/Joint Pain	33	25.0	31	23.5	64	24.3
More Than One Illness	78	59.5	75	56.4	153	58.0
Others	7	5.0	7	5.5	14	5.3
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

From table 4.17, the study revealed that 59.5 percent as against 56.4 percent who reported more than one illness were from the urban areas, 25 percent of the urban as against 23.5 percent of the rural areas were suffering from bodily/joint pains. More people (3.8 percent) from the rural areas suffered from eye disease than the urban areas (0.8 percent) this could be water related or insect attack which has resulted to that. Diabetes and heart related diseases were also found to be relatively higher in the rural areas (2.3 and 6.8 percent respectively) than in the urban areas (0.8 and 4.6 percent respectively). The reason however could not be readily explained and needs further investigation clinically. Comparatively however, stroke was significantly related with the urban communities (2.8 percent) than with the rural communities (1.0 percent). This could however be attributed to the strong involvement of the rural communities in brisk activities, including farming, walking at long distances as part of their daily activities even at the old age. In addition to making money for their upkeep with

this brisk activity even at their old age, knowingly or unknowingly it kept them fit. Averagely, heart related disease like hypertension was 5.7 percent, higher than the national average figure of 2.7 percent(GSS, 2005).The other illness however includes malaria, stomach-ache and other common head-ache which some of them suffer from. This implies that, the aged suffer numerous and multiple life threatening diseases and therefore would need adequate attention in relation to healthcare and other health supporting services/activities such as adequate healthcare, appropriate exercises and enough social interactions to keep them healthy for national development.

4.5.5 Means of Sustaining Health

Besides seeking regular medical care, there were other means by which individuals sustained their health or better still, kept themselves healthy/fit.

Table 4.18: Means of Sustaining Health

Community / Means	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Regular Exercise	20	15.3	60	45.1	80	30.3
Balanced Diet	6	4.6	5	3.8	11	4.2
Drug/Regular Check-Up	101	77.1	66	49.6	167	63.3
Adequate Rest	2	1.5	2	1.5	4	1.5
Others	2	1.5	0	0	2	0.8
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

The study revealed that as high as 63.3 percent of the aged averagely relied more on the use of drug/medical check up to maintain or sustain their health and very significantly 77.1 percent of them were from the urban communities whilst 49.6 percent from the rural communities. This shows how especially the aged population abuse drug under the pretext of sustaining their health. It is highly significant that, an average of 30.3 percent of the aged population who believed and aware that regular exercise is another way of sustaining ones health, only 15.3 percent were from the urban communities and as high as 45.1 percent were from the rural communities. Hence most of them still engaged in brisk kind of activity like farming and others which involved walking, bending or squatting, throwing of hands and others even in their old age and this help keep them fit as much as possible. There was

however, only few (1.5 percent) of the aged practicing adequate rest as a way of sustaining healthy conditions (Table 4.18). This shows how people disregard rest in their working life.

4.5.6 Physical Impairment of the Aged

It is quite simple and easy to associate physical impairment like blindness and other physical incapability with the aged population. The research however, revealed that averagely 84.8 percent of the aged had no physical impairment representing 88.5 and 81.2 percent from the rural and urban communities respectively.

Table 4.19: Physical Impairment of the Aged

Community / Response	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Yes	25	18.8	15	11.5	40	15.2
No	106	81.2	118	88.5	224	84.8
Total	**131**	**100.0**	**133**	**100.0**	**264**	**100.0**

Source: Field Survey, June, 2011

With an average of only 15.2 percent representing 18.8 and 11.5 percent from the urban and rural communities respectively who have some physical impairment. This implies that physical impairment was not directly related to increased in age, although, the aged has some resemblance with weakness in some body cells. This suggests that, it is not necessarily the increased in age that makes one impaired rather illnesses, therefore if the aged is helped socially, physically, financially, psychologically and even on health wise including regular exercises, they could live longer without becoming a burden or impairment (Table 4.19).

4.6 Challenges of the Aged

This section discusses some of the various challenges the aged encounter to sustain their wellbeing. These challenges include cost of healthcare, financial difficulties, health and housing challenges as well as social challenges.

4.6.1 Some Challenges of the Aged

The aged faces a number of challenges due to their vulnerability in terms of health, financial and social considerations.

Health Challenges

This has to do with the health needs of the aged. As a result of numerous social and psychological problems encountered by the aged in society including their previous lifestyle, some of the aged suffered perpetual health problems and this make them vulnerable. The study has revealed that, 51.5 percent of the aged population in the study area representing 48.1 and 54.9percentof the urban and rural communities respectively has health challenges (Table 4.19).

Cost of healthcare

This involves the cost one incurs in accessing healthcare services. About 60.3 percent of the aged population in the study area representing 61.1 and 59.4 percent of the urban and rural areas respectively saw cost of healthcare as a critical issue that affects their very existence amongst the society. This in relation to their incomes which is relatively low and expenditure relatively high creates huge imbalances in their socio-economic life. It implies, if the average cost of treatment or medical care is high, there is the possibility that the aged may not seek appropriate medical care and this may lead to a complexity of health life and early pass-off (Table 4.19).

Financial Difficulties

This is another critical area which underpins the very existence of the society in general and the aged in particular. It measures the amount of money that comes into ones custody and has the right to spend on ones needs. This is where most of the aged were found wanting; due to their health conditions, they are not able to work much whilst others have been legally forced out of employment because they are 60 years of age. The study revealed that, averagely 90.9 percent of the aged population interviewed had financial difficulty and found it difficult meeting their health as well as housing and social needs. For instance, monthly mean expenditure on food and healthcare alone (according to table 4.3 and 4.4 of this study) is about 143.86 Ghana Cedis depending on the size of the household. The highest and sustainable income earner however was pensioners who received a mean income of about

139.42 Ghana Cedis and only 22.3 percent of the aged received pension. About 90.1 and 91.7 percent of the urban and rural areas respectively suffered this handicap (Table 4.20). This is because at the end of the day all these and other needs aggregate into monetary value.

Housing Challenges

Ghana as a nation has a general problem in relation to housing deficit. It is reported that, currently the Ghana's housing deficit stood at over 1.5 million (Mensah, 2012).However, the aged population did not see it as a major challenge in terms of needs assessment. An average of about 30.6 percent of the aged with 38.3 and 22.9 percent of the urban and rural areas respectively saw housing as a challenge to the aged. According to the aged, the housing problem facing the aged population is not necessarily the physical access, rather the financial access (Table 4.20). They therefore quantified it into financial challenges.

Social Challenges

Social care is a basic need of every vulnerable group especially the aged. It helps reduce their emotional and psychosocial stress which research has shown that, it is number one health deteriorating or buffering tendencies like cancer among the aged and hence leads to either their early passing-off or long-life (Teye, 2011). It has many linkages including their health and financial conditions. If their social conditions are good enough, it reduces their emotional stress and their health condition is not aggravated rather, it improves.

Table 4.20: Challenges Faced by the Aged

Community / Challenges	Response [in Frequency (F) and Percentage (%)]					
	KMA		BDA		Overall	
	F	%	F	%	F	%
Healthcare Cost	80	61.1	79	59.4	159	60.5
Financial difficulties	118	90.1	122	91.7	240	90.9
Health Challenges	63	48.1	73	54.9	136	51.5
Housing challenges	50	38.3	31	22.9	81	30.6
Social challenges	67	51.1	77	57.9	144	54.5

Source: Field Survey, June 2011

If their financial condition is also bad, it degenerates into high emotional stress which would affect their health situations (Table 4.20). The study revealed that, averagely 54.5 percent of

the aged population experienced some form of social challenges. About 51.1 percent and 57.9 percent of them were from the urban and rural communities respectively. This deviates from the usual order where it is a believed that, those in the rural areas are closely knit together and therefore would sought some kind of social interactions among themselves than those in the urban communities who are more individualistic and therefore do not associate more due to their cosmopolitan nature.

This could also be as a result of people leaving their aged relatives to seek greener pasture which is relatively pronounced in the rural areas. Again, the study indicated that more aged people in the urban communities are catered for by their spouses (36.6 percent) and children (41.2 percent) than their counterparts (35.3 and 34.6 percent) respectively in the rural communities (Table 4.20).

It could be observed from the above (Table 4.20) analysis that the aged ranked the financial difficulties at 90.9 percent as the biggest challenge to their survival. This is because all other needs are financially related or valued. The next consideration is the healthcare cost at 60.3 percent, followed by social challenges at 54.5 percent. Health challenges is the fourth of their ranking at 51.5 percent while housing challenges which is 30.6 percent is considered the least ranked. This is because according to the aged, their difficulty has to do more with financial access than physical access.

4.7 Other Source of Support to the Aged

This section discusses the other sources of support that the aged received to complement their wellbeing. These sources included caregivers, religious groups such as Christians/orthodox, Islam, Pentecostals /Charismatic, as well as the Sabbaths.

4.7.1 Support from Caregivers

From the study it was revealed that, the caregivers were very essential in the wellbeing of the aged. They gave social and psychological support, financial support, healthcare support and some gave housing support all geared towards the wellbeing of the aged. In given these support according to the study, the caregivers faces some challenges which includes punctuality and regularity to either work or school especially those who are still in school.

They emphasized the fact that, it becomes very necessary sometimes to abandon every activity or programme to help the aged to seek medical care and other necessary support.

About 40.4 percent reported of not being regular and punctual at work because they need to take care of their aged parent/relative before leaving for work. They were also need to rush back to the house from work before closing time. Another 23.1 percent who were still in school complained of interruptions and disruptions in their studies because they have to attend to the call of their aged relative/grandparent. About 28.8 percent also complained of financial burden upon them as they care for their aged relative in addition to their nuclear family.

4.7.2 Suggested Solutions from the Caregivers

The following suggestions were therefore made by the caregivers, about 96.2 percent believed that a means of social support measure be instituted to relieve the caregivers of some of these difficulties. About 80.8 percent of the caregivers thought that financial support for the aged could help reduce the burden of the aged while 73.1 percent also agreed with free health care support as a means of reducing the financial burden on both the aged and the other caregivers.

4.7.3 Support from the Religious Institutions

Some religious institutions were also sampled for interview and according to the study; about 40 percent of the religious bodies gave support to people including the aged outside their institutions while 60 percent responded negative. It was also revealed that some of the religious institutions encouraged their members to give support in the form of money, clothing, food and visitations to the aged in their institutions/churches; however, they were not very much reliable.

4.7.4 Criteria for Supporting the Aged

According to the study, as indicated in the Table 4.21, about 80 percent of the religious institutions based their criteria of support on one's welfare membership in the church, 50 percent on commitment or previous commitment to the church if incapacitated and 70 percent on regular payment of dues while 60 percent was on clear indication of need. It was also revealed in the study that 40 percent gave the support to their aged people once monthly

while 20 percent gave once every year and the other 40 percent also gave support as and when resources are available. This shows that the religious bodies do not support based on humanitarian grounds or vulnerability.

Table 4.21: Criteria for Supporting the Aged

Response / Criteria	Frequency	Percentage
Membership of Welfare	8	80
Contribution	7	70
Level of Need	6	60
Level of Commitment	5	50

Source: Field Survey, June 2011

4.7.5 Kind of Support Given to the Aged

The religious groups gave the following support to the aged, it included housing, financial, social and health supports.

Table 4.22: Kind of Support for the Aged by the Religious Bodies

Response / Support Type	Frequency	Percentage
Housing Support	4	40
Financial Support	10	100
Social Support	7	70
Health Support	4	40

Source: Field Survey, June 2011

According to the study all the religious groups (100 percent) gave social support to the aged in the form of counselling, praying and visitations. The other included financial support which 70 percent of the religious bodies responded positive. About 40 percent gave some kind of health support to the aged in the form of payment of part of medical expenses and sometimes helped to register some of those below 70 years for the NHIS when the need be. About 40 percent gave housing support in the form of part payment of rent to some of the aged when it becomes very necessary (Table 4.22).

4.7.6 Sources of Funding the Support

The study has revealed that the religious groups gave some support to the aged group in their churches. Therefore the study sought to investigate into the sources of funding the support. All the religious bodies (100 percent) agreed that the main source of funding their welfare fund is from the internal source in the form of general offering, membership dues and launching of special offering. About 80 percent of the religious groups depend on individual donations and is done willingly which some of them termed it *"mercy fund"*. Another 80 percent of the religious institutions also received some donations from guests who were invited on special occasions and decide to donate to the welfare fund in support of the aged (Table 4.22).

4.7.7 Difficulties of the Religious Groups

In giving this support, the religious bodies encounter some difficulties such as inaccurate records. About 40 percent reported inaccurate records for members of the church no matter how data base is put in place, hence the use of welfare membership as a way of identifying members for easily assessing the needs and supporting them. About 50 percent also reported of non-payment of dues. The challenge however was that, the very people who are in need are the same people who were required to pay some dues to become members before receiving or qualifying for support. There were other challenges where 70 percent of the groups complained about and this has to do with other socio-cultural dynamics which usually affects decisions taken on welfare issues (Table 4.22).

4.7.8 Institutional Support for the Aged

The various institutions which have something to do with the aged in society includes the District Assemblies (DA),Department of Social Welfare (DSW) and Compassionate African Aged Foundation (CAAF) an NGO. According to the Local Government Act, 1993, Act 462 the DA has the direct control of development at the local level on behalf of the central government. The study revealed that DSW on behalf of the District Assembly seek the welfare of the vulnerable including the aged as in line with the decentralization policy of the country. These decentralized institutions including DSW are the implementing agencies of the policies of the Assembly. The support given by the institutions to the society include financial, social, housing and healthcare support.

Financial Support

The study revealed that the institutions have no clear cut policy to supporting all the aged financially. The only policy which sometimes reliefs some of the aged include the poverty alleviation programme called "LEAP" which is implemented at a selected districts in the country where according to the study only one percent of the aged received. This LEAP is meant for the needy/poor including the aged, however based on the criteria of the DSW such as income/level of poverty, the nature/state of housing conditions and other deprivations including lack of assets such as land and lastly demography and health including the level of chronic diseases and isolation. However, for the past three years there has not been any disbursement of such funds to those who suppose to receive until between March and June 2012. The other is national pension scheme implemented by the SSNIT. It is meant for only contributors of the scheme and only few people who were in the formal employment qualify. In view of this 75 percent of the institutions agreed for financial support for the aged in order to enhance their general wellbeing.

Housing Support

The study indicated clearly that, housing is privately owned and even if one occupied an institutional accommodation, the beneficiary had to depose himself/herself of the said accommodation on retirement at the age of 60 years. This therefore made most of the aged resort to rented accommodation if he/she was not able to build for himself/herself an accommodation. Another form of accommodation for the aged identified by the study was the "aged home" managed by the DSW and the aged destitute who are referred to that "aged home", however it could accommodate only few aged. The study indicated that 25 percent of the institutions suggested for housing support to relief the aged of some housing problems.

Healthcare Support

According to the study, 50 percent of the institutions agreed to the support of the healthcare needs for the aged. This is because, the study indicated that the only healthcare policy that go to support the aged was the NHIS where only those 70 years and above whose registration and renewal is subsidized. It was also revealed that, the availability of health insurance encouraged more aged to seek appropriate medical care.

Social Support

About 75 percent of the respondents from the institutions agreed for social support intervention. According to the study there was no clear policy on social support for the aged. The only known programme being implemented was the "Senior Citizens' Day" celebration, where special occasions like the Republic Day, the aged (senior citizens) are invited for a feast. But this is not sufficient enough to relief them of social distress. And even, not all the aged in society either receive invitation or able to make it to that feast. It was also revealed that others also get some support from their family members or caregivers.

4.7.9 Criteria for Institutional Support

The study revealed that the major criteria of selection for support were that, one must be an aged of not less than 65 years and without subsistence support or orphan, vulnerable, child or a person with severe disabilities and without productive capacities based on DSW criteria to qualify for LEAP, or should be 70 years to qualify for NHIS. The major problem however was inadequate funding, inadequate personnel and unreliable data/records example is birth certificate of the aged as well as the age differentials for the various social interventions for the aged and finally the selection process for the LEAP eligibility.

It is observed therefore that, social and financial supports were ranked higher at 75 percent each, followed by healthcare support at 50 percent. The least ranked issue however, according to the views of the institutions was housing support. This implies, social and financial support is the major considered issues of the society.

CHAPTER FIVE

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This section of the report being the concluding chapter of the study summarises the findings of the research. This also indicates how the objectives of the study were achieved. It also provides useful policy recommendations that address the issues raised in the analysis to ensure the wellbeing of the aged in the society. This has been put under various headings to improve on the presentation.

5.2 Summary of Findings

The findings of the study are based on the objectives of the research. This section therefore identifies issues concerning the financial, social, housing and healthcare concerns of the aged and also how national policies have been directed towards achieving their wellbeing for national development. This has been listed under the various sub-headings for clarity.

5.2.1 Socio-Economic Characteristics

The study revealed that:

- About 52 percent of the aged in the rural communities have not been to school before as against 45.8 percent in the urban communities. Averagely 48.9 percent of the aged in the study areas have not been to school before. This affected their employment status and income levels.
- As high as 61 percent of the aged are without marital partners, 40 percent of them are widowed and 21 percent divorced.
- About 30percent of the female aged widowed as against 5.7 percent of the male aged were widowed. It indicates that the females live longer than their male counterparts and the males relatively enjoy social intimacy than the females.

5.2.2 Financial Situation of the Aged

The study indicated that:

- Majority of the aged encounter financial difficulty whenever their source of income support failed. It is evident that 63.3 percent depended on unsustained or insecure income, either remittances or gifts from other sources. While only 36.7 percent of the

respondents depend on sustained or secured income (income they have control over) such as pension, return on investments or rent property.

- The aged have a high cost of living, this is because the food component of the cost takes the chunk of their total income. The monthly average cost of the food component is as high as 137.80 Ghana Cedis representing 77.4 percent of their expenditure. This is likely to lower their standard of living making the majority poorer.
- The aged continued to engage in labour intensive occupation and depend on it as living income not as leisure though physically, they are not as strong as those in the active population. It is evidenced that those engaged in agriculture activity increased from 32.2 percent in the previous occupation to 42.4 percent in the current occupation. While service/commerce reduced from previous 51.5 percent to current 26.5 percent though agriculture and service/commerce are still dominating in relation to other sectors in terms of employment. They used this either as their main source of income or to supplement their other sources of income.
- About 38.6 percent of the aged suffer partial hunger and this could affect their health conditions. They eat twice a day and even lacked the adequate nutritional quality and quantity and this have the tendency to affect their health situation since nutrition is important aspect of health conditions to every individual.

5.2.3 The Housing Situation of the Aged

It was indicated by the study that:

- About 45.8 percent of the aged lived in the family house and 32.2 percent also lived in rented housing. This shows that, about 78percent of the respondents do not own a house and therefore depended on other means for living and therefore has the tendency to interrupts their peace and security.
- In rural and urban dichotomy, about 66.9 percent of the aged from the rural areas lived in their family house while 61.1percent from the urban areas lived in rented housing. Averagely, about 64.1 percent who are in the majority are burdened in relation to accommodation because they do not own a house for themselves. However, the 61.1 percent in the urban areas suffer more with this regular increase of rent advances and its concomitant problems.

- Majority of the aged have relatively lower standard of living considering the kind of toilet facility they access and where it is accessed. About 90.1 percent from the urban and 96.3 percent in the rural communities or averagely, 93.2 percent in the study area used both KVIP and pit latrine toilet facilities alternatively. While 80.7 percent accessed it from the public facility outside the house. This force them to squat and it affects and worsens their health situation due to the knee and joint pains they suffer from.
- Water related disease is very minimal or non-existence in the study areas since majority of them have access to potable water. It is evidence that an average of 90.1 percent has access to potable water in the study area and therefore has the tendency of improving their health situation.
- Financial difficulty is the major limitation to the aged for using electricity and/or gas for cooking. It is evident that about 84.5 percent of them have access to electricity for lightening yet, only 10.2 percent used electricity/gas for cooking in the study area. Whereas over 80 percent used either charcoal or firewood for cooking. This has the tendency of exerting more pressure on the environment.

5.2.4 The Level of Social Support to the Aged

The study revealed that:

- Averagely, about 64 percent of the aged do not live with their spouses and therefore may lack adequate social interaction and suffer social intimacy. This could lead to frequent stressful conditions and breakdown of healthy conditions. The only 36 percent who lived with their spouses may enjoy relative conducive social interaction and intimacy for healthy life.
- About 97.3 percent prefer staying with and caring for their own aged family members or living them in the care of their children/grand children who sometimes attend school rather than in the care of hired caregivers. They damned the consequences or the effect on their job or the education of their children.
- Different aged individuals used different means of reducing stress or breaking boredom. It was indicated in the research that a number of options were available; however majority of the aged representing about 47 percent used regular visitations of friends as a means of reducing stress or breaking boredom. This helped them to improve on their health conditions.

5.2.5 The Healthcare Situation of the Aged

Investigation revealed that:

- Self-medication seems to be a frequent habit among the aged as a result of regular bodily/joint pains and other sufferings some of them go through. This is due to unfriendly nature of the hospitals towards the aged and the routine nature of medication administered to them as well as the perceived ineffective operations of the national health insurance scheme for the aged.
- An average of 63.3 percent of the aged depended more on the use of drug/medicine to sustain their health. About 77.1 percent of them were from the urban communities whilst 49.6 percent from the rural communities. It means most of the aged used self-medication which might be dangerous to their health condition. About 83 percent of the aged population used both cash payment and the health insurance to access healthcare. This is because certain services and medications are not covered by the national health insurance scheme and that could be one of the driving forces that encourage the self medication.
- More of the aged suffered multiple illnesses; this might be as a result of old age which made them susceptible to illnesses. As one increases in age the immune system reduces in its effectiveness or sometimes the previous lifestyle affects the immune system to malfunction. It is evident in the study that, about 58 percent of them reported more than one illness to the health facility they chose.

5.2.6 Other Sources of Support

- The aged also received some support from the caregivers. From the study it was revealed that the role of caregivers was very crucial in the wellbeing of the aged. They gave social and psychological support, financial support, healthcare support and some gave housing support all geared towards the wellbeing of the aged. They emphasized the fact that, it becomes very necessary sometimes to abandon every activity or programme to lead the aged relative to seek medical care.
- The main support the religious bodies gave was counselling, praying and visitations of the aged. About 70 percent of them in addition gave financial support with 40 percent adding some form of health support.
- The aged who are outside the religious institutions/church do not receive any support from them. About 80 percent of the religious institutions based their criteria of

support on welfare membership in the church, 50 percent based it on ones commitment to the church and 70 percent on regular payment of dues while 60 percent also based it on a clear indication of need of members.

5.2.7 Support from the Institutions

The study revealed that:

- Housing is privately owned and even if one occupied an institutional accommodation, the beneficiary had to depose himself/herself of the said accommodation on retirement at the age of 60 years. Therefore those unable to build for themselves an accommodation would continue to battle with the exorbitant rent advances and its concomitant problems.
- The only known social programme for the aged being implemented was where some occasions especially the Republic day some of the aged in society were invited for feast. However only few of them received and honour the invitation, one day feasting may not be enough to boost their socio-economic ego.

5.2.8 Source of Funding the Support

- The study revealed that all the religious bodies (100 percent) receive their funding from internal sources such as membership dues, special offering and welfare fun termed *"mercy fund"*.
- The only regular and secured financial support the aged received from the institutions was those on regular or SSNIT pension's scheme. Those who were self-employed received no financial support from the institutions.
- Those identified as poor were supported through the LEAP fund though it is still on pilot stage within few communities. It is not necessarily directed to the aged, rather open to everyone classified as poor based on DSW's owned criteria.

5.2.9 Challenges in Relation to the Support

The research identified that:

- About 60.3 percent of the aged population in the study area saw cost of healthcare as a critical issue that affects their very existence amongst the society. This in relation to their incomes which is relatively low and expenditure relatively high, it creates a huge imbalance in their socio-economic life. Therefore if the healthcare cost is high, they

may not seek appropriate medical care and may lead to a complexity of health life and early pass-off.

- The caregivers reported a number of challenges they encounter in their bid to support or care for their aged ones. It includes punctuality and regularity to work, disruptions of school activities, overburdened financial and other difficulties. The study revealed that, about 40.4 percent of the caregivers reported of not being regular and punctual at work as a result of caring for the aged. About 23.1 percent complained of disruptions in their studies at school in caring for their aged relative/grandparent. About 28.8 percent also complained of financial burden as they care for their aged relative, especially where their incomes are low and also have a large household size.
- An average of90.9 percent of the aged population interviewed had financial difficulty and found it difficult meeting their health as well as housing and social needs. This is because all these needs aggregate into monetary value.
- The research indentified inaccurate or poor records, financial difficulty and socio-cultural dynamics that usually affect decision taken on welfare issues as some major challenges that faced the religious institutions in supporting the aged among them.

5.3 Recommendations

The health insurance policy should be reviewed by government where the age at which one enjoyed free or subsidized premium payment be reduced from 70 years to 65 years. At age65, everyone is expected to have gone on compulsory retirement from active formal employment, even if he/she had had an extended employment contract, it might have ended.

It is said that "knowledge is power…" Education should be made as accessible as possible to every child of school going age by the government. It has the power to shaping ones thinking and widens ones horizon. There is a popular saying, "if one thinks education is expensive, one should try ignorance". Education has the power to influence the kind of job one does and the best way of doing it. When the people are well educated their employment status is improve for an enhanced remuneration. Even when one is in the informal sector, it has the possibility of improving the way things are done for an enhanced income or profit. It also makes one sensitive to one's health and therefore seeks knowledge to improve its health conditions. It could also help increase the understanding of investments. All these would help improve the wellbeing of the aged.

A fund should be created by the government and call it "Aged Fund" to support the aged, who are prone or susceptible to health, social, financial and or other challenges that could make them miserable and or destitute. This could be done by deducting certain percentage of the District Assemblies' Common Fund (DACF) and tax like VAT paid into that fund. This would help widen the tax net to cover all those in the informal sector who otherwise would not have paid tax. The general public, NGOs and other civil society groups should be encouraged by government to contribute to the fund as part of their social responsibilities to the society. When the people are aware that the taxes and other contributions towards this course would inure to their long term benefit, they would gladly commit themselves to it.

The government should establish a long term and generally accepted housing policy to support the people especially the aged to own a house while they were in their active working age. The already established associations/welfares, credit unions and other groupings could be used as a vehicle to realize this. Members of these groups could compulsorily be made to commit certain percentage of their monthly income towards housing like the SSNIT pension contribution for workers and the government guarantees for the beneficiary. Typical case is the SSNIT housing scheme where their housing units have been given out for outright purchase by the occupiers. Another is the affordable housing scheme though the prices seem to be expensive, the concept was laudable. To make it relatively affordable, local building materials should be employed. This would help reduce the housing deficit, increase access to housing and finally improve the wellbeing of the aged.

There should be a policy to establish social centres in the communities by the government with support from other interest groups and managed by a Board. Human beings function in a social system through interpersonal relationships which influences their life and health (King, 1981).The aged within the community meet to entertain and educate themselves on issues of common interest including health/nutrition and personal hygiene. The aged being recognized as repository of culture and tradition, could make the place serve as experience and knowledge sharing centre for the general public particularly the youth as well as the schools within the catchment area. This would help to educate the children and the youth about culture and tradition; it would go a long way to preserve culture as well. It would again be used as aged community health centre where health personnel would visit them at regular intervals to screen and administer the appropriate medicine to them and make the necessary referrals if special medical attention is required. This could help reduce the aged 'flooding'

the hospitals without receiving the necessary attention they require. It could also help reach out to the aged easily enough for any necessary educational issues including their health. The burden on caregivers as well as stress and self-medication could be reduced. These would possibly improve their social interactions and reduce their health challenges all gear towards ensuring their wellbeing and also become useful in the society.

The DSW should be well resourced by the government with personnel, logistics and financial to carry out their social welfare activities including counselling to support the aged on their psychosocial imbalances. It should again spearhead the monitoring and evaluation of the activities laid out for the aged; ensures their appropriateness and suitability to support the wellbeing of the aged. They should also ensure the appropriateness and adequate utilization of the funds made available for the activities towards the wellbeing of the aged.

The religious groups should be encouraged by the government to support the aged by contributing to the fund as their social responsibility. They should continue their spiritual and psychosocial support to the aged including regular visits to the aged at the centres; the essence of the existence of the religious bodies besides making people belonging to God. This would ensure that, the wellbeing agenda of the aged is realized.

There should be a policy which ensures that the capacity of the Caregivers is built by the centre on psychosocial and physiological understanding of the aged through training. This would help ensure proper handling of the aged especially the bedridden ones. Guidelines and code of conduct should be spelt out to direct the attitudes of the caregivers towards the aged that they care for. The management of the social centres would lead this training programme and DSW monitors their activities including the conducts of the caregivers. All this would ensure the well-being of the aged for national development.

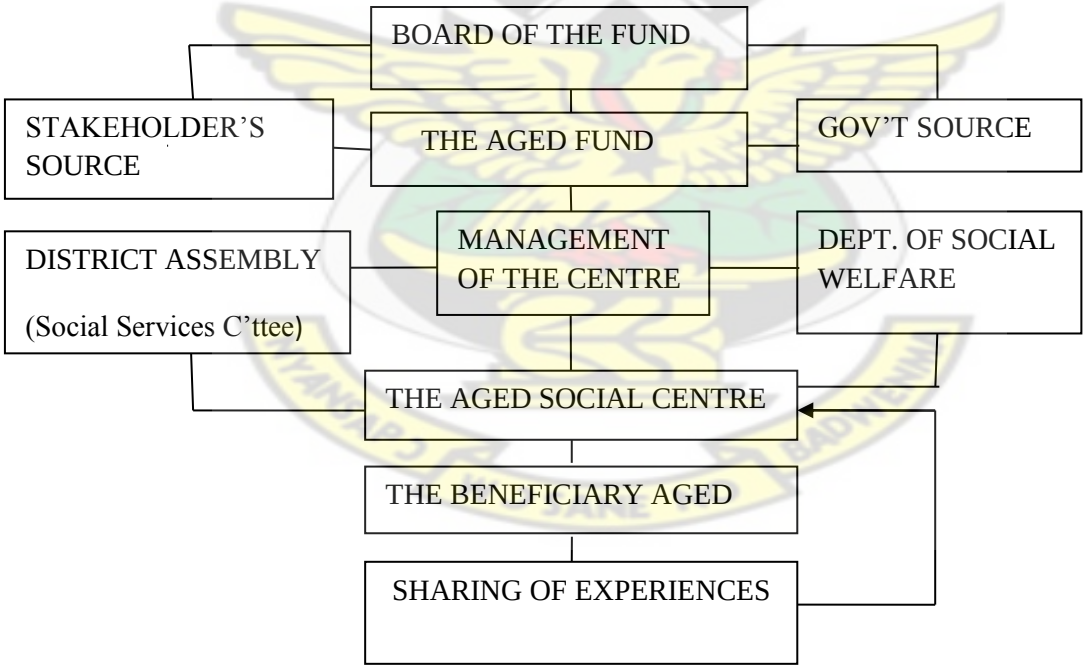
There should be institutions put in place by government to ensure proper management and control of funds and activities for the benefit of the individual aged groups and the caregivers for total development.

A Framework of Institutional Arrangement for the Aged Wellbeing

This is an institutional arrangement which sought to mobilize funds to manage the centre that ensures the wellbeing of the aged.

According to the Figure 5.1, a board must be constituted which is at the apex. The board would mobilize and manage the funds from both government and other sources and then disburses them to the various centres. Under the board is the aged fund which is the custody of all the mobilized funds. The management committee at the aged social centre organizes programmes and activities for the wellbeing of the aged. The social services committee which is one of the sub-committees of the Assembly in-charge of social services and the department of social welfare would monitor the activities and programmes implemented at the centre including the utilization of the funds. The aged social centre implements the various programmes and activities for the wellbeing of the aged. The beneficiaries, who are the aged, receive these programmes and activities which go to improve the health, social, financial and housing conditions of the aged. The aged who have benefited from these programmes and who are also the custodian of culture and tradition share their experiences of life and culture with the public especially the youth. All these would go a long way to ensure the wellbeing of the aged for national development.

Figure 5.1: Institutional Arrangements for the Operations of the Aged Fund



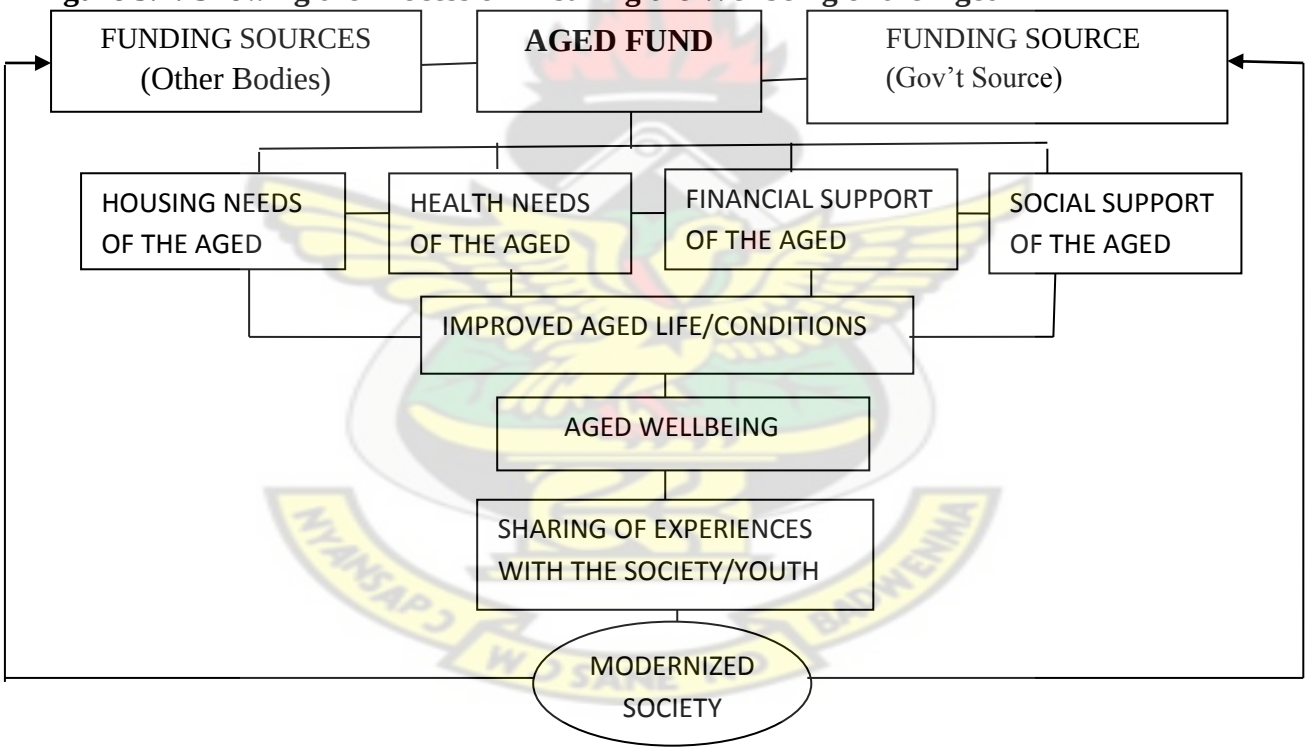
Source: Author's Construct, June 2011

A framework for Aged Wellbeing

This framework explain the processes of ensuring a comprehensive aged wellbeing by relating and coordinating the various levels and stages of the framework as indicated below

From the Figure 5.2, a fund is created by the government called "the Aged Fund" where at least 95 percent of the amount is contributed from government coffers and the rest five percent is contributed by other partners (religious bodies, NGOs, and other possible sources) and managed by a Board. The fund is disbursed equitably to the centres and the management of the centres appropriately finance the activities (healthcare, financial, social and housing support) at the centre to ensure the wellbeing of the aged. The activities including the utilization of the fund at the centre would be monitored by DSW to ensure its suitability to the aged needs. The aged then share experiences among themselves and educate the public including the youth on the culture and other experiences to help create a modernized society. This society would then pay their taxes to enable the government raise revenue to support the aged fund while others directly contribute to the fund.

Figure 5.2: Showing the Process of Ensuring the Wellbeing of the Aged



Source: Author's Construct, June 2011

Creation of aged fund would be a laudable venture to support the aged in reducing their poverty and vulnerability.

5.4 Conclusion

The study has revealed that, all the issues discussed such as financial, social, healthcare and housing issues are very critical to the wellbeing of the aged. Therefore, if an appropriate and effective policies and programmes are directed towards them, they could become useful and beneficial to the society. The role of the aged as gatekeepers of culture and tradition as well as conflict resolution and also where people consults when critical decision is needed to be taken would be upheld in the face of societal indiscipline particularly among the youth would be enhanced. However, their exclusion in national development coupled with societal suspicion and name calling seem to have eroded this gain.

Again, when opportunities are created particularly for the rural communities to have access to formal education, it would widen their scope of job opportunities. This would help reduce poverty among them as well as the labour intensive occupation most of the aged engaged themselves in. This could enable them own house with an appropriate toilet and other necessary facility for their comfort. These have the tendency to improve their standard of living and health conditions.

The multiple illnesses couple with disinterest in the hospital operations by the aged has contributed to some of them resorting to self-medication in the view of reducing their bodily/joint pains. Some of the aged also used social interaction including visiting of friends to reduce stress and this improves their health conditions.

Institutional support for the aged including religious and governmental levels seems to be very low. This point to the fact that the issues of the aged in Ghana do not matter much to the society in particular and the nation as a whole. The true meaning of old age as a blessing from God but not resemblance of perpetual illness, curse and misery could be realized and people would be confident and happy to live longer.

REFERENCES

American Housing Survey (1997), Assessing Housing Needs of the Elderly, Housing Our Elders:A Report Card on the Housing Conditions and Needs of Older Americans,USA:Housing and Urban DevelopmentUser**.**

Antonovsky A. (1987), Unravelingthe Mystery Of Health: How People Manage Stress And Stay Well. San Francisco, California:Jossey –Bass

Andersson L., Ensamhetoch (2002), Social Relation Ed. in Social Gerontology; StudentLitterateur; Lund. P. 146-65.

Babbie, E. (2007). The Basic of Social Research. United States of America: Wadsworth

Baiden, F., Hogson A. and Binka F. N. (2006). "Demographic Surveillance Systems and EmergingChallenges in International Health":*Bulletin of theWorld Health Organisation*,vol.84, no. 3, pp. 161-256.

Bass, D. M., McClendon, M. J., Brennan, P. F., & McCarthy, C. (1998).The Buffering Effect of SupportNetwork on Caregiver Strain:*Journal ofAging andHealth*, 10,(1), 20-43.

Bassuk, S. S., Berkman F. L., and Amick C. B. (2002). "Socioeconomic Status and MortalityAmong the Elderly: Findings from Four US Communities":*American Journal ofEpidemiology*, vol. 155, no. 6, pp. 520-533.

Binstock, R. H. & George, L.K. (2001).*Handbook of aging and the social sciences* (5th ed.). London:Academic Press.

Binstock and L. K George (Ed), Handbook of Ageing and Social Sciences.New York:Academic Press.

Bosomtwi District Assembly, (2010). The Profile of Bosomtwi District Assembly; District Planning and Coordinating Unit: BDA.

Bowen, R.L and Atwood, C.S.,(2004).Definition and Characteristics of Ageing: www.cmp.wisc.edu/faculty/bio.php.[Retrieved, July 8,2012].

Bruzeilus, K., Teng, W.S. (2010). "I fellWell Even Though I Have Illnesses" Elderly People's:http://www.google.com.gh/search?[Retrieved, May 7, 2011]

Catalano, R. (2002). "Economic Antecedents of Mortality among the Very Old": *Epidemiology*,vol.13, no. 2, pp. 133-137.

Cobb, (1976).Cited by DelgardinSocialSupport - Definition and Scope: EUphix,EUphact. Bilthoven:RIVM.[http://www.euphix.org, euphact\determinants ofhealth\environment\social support].

Cohen, L., Manion, L. and Morrison, K. (2007).Research Methods in Education.Great Britain: MPG Books Ltd, Bodmin.

Dalgard O.S. (2009), Social Support - Definition and Scope: EUPHIX, EUphact. Bilthoven: RIVM. [http://www.euphix.org, euphact\determinants of health\environment\social support].

DalgardO.S.(1995).Cited inSocial Support - Definition and Scope: EUPHIX, EUphact.Bilthoven:RIVM.[http://www.euphix.org, euphact\determinants of health\environment\social support].

Daniel J., Curran, Claire M. Renzeti (1993), Social Problems: Society in Crisis. 3rd Ed. Allyn and Bacon.A Division of Simon and Schuster, Inc. St. Joseph's University. 160 Gould Street, Needham Heights, MA 02194.

Davis, K., P. Grant and D. Rowland (1990), "Alone and Poor: The Plight of Elderly Women"Generation, 14 (summer): 43-47.

Eisner, E. W. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. New York, NY: Macmillan Publishing Company.

Eliopoulos C. (2001). Gerontological Nursing.(5th Ed.)Philadelphia:Lippincott.

Frankfort-Nachmias, C. and Nachmias, D.(1992).Research Methods in the Social Sciences(4th Ed.), Milwaukee:University of Wisconsin

Ghana Statistical Service, (1998).*Ghana Core Welfare Indicators Questionnaire Survey, 1997.* Accra:GSS.

Ghana Statistical Service, (2005).*Population Data Analysis Reports, Volume 2; Policy Implications of Population Data Trends.* Accra:GSS

Ghana Statistical Service, (2005).*Population Data Analysis Reports, Volume 1; Socio-Economicand Demographic Trends Analysis.*Accra:GSS.

Ghana Statistical Service, (2005). Health, Nutrition and Environment Statistics: Report

Golant, SM, (1984), A place to Grow Old. New York: Colombia University Press.

Göteborg (2004), Department of geriatric medicine,Sahlgrenska academy. Sweden: Göteborg University.

Gunnarsson E. (2009) "I Think I have had a Good Life": The Everyday Lives of Older Women and Men from A Life course Perspective. Ageing Soc.; 29:33-48.

Hansson A. (2009), Subjective Well-being in an Adult Swedish Population: Findings from aPopulation-Based Study [Dissertation]. Stockholm:Karolinska Institute.

Holden, K.C. (1988), "Poverty and Living Arrangements among Older Women: Are Changes in Economic Wellbeing Underestimated?" Journal of Gerontology: Social Sciences 43: 522-527.

Holmén K, Furukawa H. (2002), Loneliness, Health and Social Network among Elderly People:a Follow up Study. Arch GerontolGeriatr.; 35:261-74.

House, (1981).Cited inSocial Support - Definition and scope: EUPHIX, EUphact. Bilthoven: RIVM. [http://www.euphix.org, EUphact\determinants of health\environment\ social support].

James T.M, (1985). The Trade, "The Wilson Quarterly", 8:107-125.

Jönson, H. (2002). *Ålderdomsomsamhälls problem.[Old age as a societal problem*. Lund:Student litteratur. [In Swedish].

Johansson, L. and Sundström, G. (2002).Anhörigvårdensomfattning i Sverige. [The Scope ofInformal Caring in Sweden]:*Social medicinskTidskrift,* **2**, 119-130.[In Swedish].

Kendig, H. L. (1990)."Comparative Perspectives on Housing, Ageing and Social Structure".Pp. 288-306 in R. H.

King, IM. (1981).A Theory For Nursing: Systems, Concepts, Process. New York: Wiley.

Kinsella, K. and Velkoff, V. A. (2001).*An aging world*. Washington, DC: US Government Printing Office.

Kowal P. R., Dowd J. E., Aboderin I. A., and Madzingira N. (2002)."Data for Older AdultPopulations in Sub-Saharan Africa", *The Lancet*, vol. 360, no. 9326, p. 91.

Kumar, R. (1999). Research Methodology. A Step By Step Guide for the Beginners, London:SAGEPublications.

Kumekpor, T. K. B. (2002). Research Methods and Techniques of Social Sciences. Accra: Sonlife Printing Press and Services.

Kunst, A. E. and Mackenbach J. P.(1994).Measuring Socioeconomic Inequalities in Health,Copenhagen:WHO.

Kumasi Metropolitan Assembly, (2010). The Profile of Kumasi Metropolitan Assembly; KMA: MetropolitanPlanning and Coordinating Unit.

Lagergren, M. (2002). The systems of care for frail elderly persons: The case of Sweden. *AgingClinical and Experimental Research,* 14, 252-257.

Lagergren, M. (2004).*The Development of Older People's Health and Longevity,* StockholmSweden: Stockholm Gerontology Research Center.

Lewin, T. (1991a) "Communities and Their Residents Age Gracefully", New York Times

Lindström B, Eriksson M. Salutogenesis J., (2005). Epidemiol Community Health.59:440-2.

Linberg-Sand, A. (1993). Omvårdnad I utbildning, yrkeochforskning. Lund:Student literature

Mensah E. T. (2012). Environment Ministry Develops New Building Policy. Accra:The Ghanaian Times,.[Retrieved 2012, March 8]. Available from: (http://www.ghana. gov.gh/ index. php/news/features/11498)

Miller, R. L. and Brewer, J. D. (2003).A–Z of Social Research. SAGE Publication Ltd. London

Ministry of Employment and Social Welfare.(2010). National Ageing Policy of Ghana. Accra: Government of Ghana.

MIPAA, (2007). Ghana Country Report on the Implementation of the Madrid International Planof Action on Ageing: Madrid

Nachmias, C. F. (1992). Research Methods In Social Sciences. Britain:St. Martin's Press Inc.

NDPC, (2005).*Growth and Poverty Reduction Strategy (GPRS II): The Co-ordinate Programme for the Economic and Social Development of Ghana (2006 - 2009).*

NDPC, (2006), Implementation of the Growth and Poverty Reduction Strategy (2006-2009): AnnualProgress Report, (2006), Accra, Ghana:Government of Ghana

NDPC, (2010). Medium-Term National Development Policy Framework: Ghana Shared Growthand Development Agenda, 2010 – 2013, vol.1; Accra, Ghana:Government of Ghana. NDPC, (2010), Implementation of the Growth and Poverty Reduction Strategy (2006-2009): Annual Progress Report, (2009), Accra, Ghana:Government of Ghana.

National Population Council, (*2005). ICPD +10 Ghana Country Report (1994 - 2004).*

NationalPopulation Council, (1994).*National Population Policy (Revised Edition).*

Olson, L.K. (ed.), (1994). *The Graying of the World: Who Will Care for the Frail Elderly?* Binghamton, New York: The Haworth Press Inc.

Oppong, C.(2006). "Familial Roles and Social Transformations: Older Men and Women inSub-Saharan Africa", *Research on Aging*, vol. 28, no. 6, pp. 654-668.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.).Newbury Park, CA: Sage Publications, Inc.

Peterson, I (1991b), "Homeownership-A Receding Dream" New York Times, 20th October, 1, 10

Ranjit Kumar. (1993). Research Methodology:Step-By-Step Guide for Beginners, London, Thousand Oaks, New Delhi:Sage Publications.

Reed, J.E.F., (2007). Social Support and Health of Older Adults. In: Sieloff CL, Frey MA, Editors. Middle Range Theory Development: Using King's Conceptual System, New York:SpringerPublishing Company; p. 92-104.

Redfern SJ, Ross FM, (2006), Editors. Nursing Older People. 4th Ed.Edinburgh: ElsevierChurchillLivingstone.

Robinson T., Mosha F., Grainge M. andMadeley R., (2006). "Indicators of mortality inAfrican adults with malaria", *Transactions of the Royal Society of TropicalMedicine andHygiene*, vol. 100, no. 8, pp. 719-724.

Schwab, T., (1989).Caring for an Aging World: International Models for Long-Term Care, Financing and Delivery, McGraw-Hill Information Services Company, USA.Publications, London, New Delhi:Thousand Oaks.

Smith, K. T and Bergston V.L (1985). Positive Consequences of Institutionalization: Elderly Parents and their Middle-Aged Children pp. 182 – 190 In H. Cox (Ed.), Annual Editions: Ageing Guildford, CT: Dushkin Publishing Group.

Steen, B. (1971-2002). To Become Old: The Gerontological and Geriatric PopulationStudies in Göteborg, Sweden:H70

Strauss, A., & Corbin, J. (1990).*Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage Publications, Inc.

Stuart-Hamilton, I. (2006). The Psychology of Ageing, An Introduction116 Pentonville Road, London N19JB, UK and 400 Market Street, Suite400 Philadelphia, PA 19106, USA:Jessica Kingsley Publishers.

Suominen S, Lindström B. Salutogenesis. (2008).Scand J Public Health;36:337-9.

Tinker, A. (1984). The Elderly in Modern Society, (2nd ed.), London and New York:Longman.

Teye, E. (2011). Coping with Aged-Related Diseases, Accra:Daily Graphic,(May 12, 2011, pg 34).

Tornstam L. (2005). Aldrandets Social Psychology. 7th Ed. Stockholm: NorstedtsAkademiskaforlag.

UN, (2008). The Millennium Development Goals Report, New York:United Nations.

UN, (1998). Household and Family Characteristics in Principles and Recommendations for Population and Housing Census Revision1, New York: United Nations.

UN-HABITAT, (2010). The State of African Cities 2010, Governance, Inequality and Urban Land Markets, Nairobi: UN-HABITAT.

UN-HABITAT, (1996). "Adequacy" Regards to Housing is Influenced by Social, Economic Conditions, HREA: Available from:(htt://www.hrea.org/index.php.doc.id). [Retrieved: July 8, 2012].

US Department of Commerce, Bureau of the Census, (1990).Money, Income and Poverty Status in the United States.Washington, DC:US Government Printing Press.

Weismann, U., Hannich, H.J.A., (2008).Salutogenic View on Subjective Well-Being in ActiveElderly Persons.Ageing MentHealth. Jan; 12(1):56-65.

World Bank (2007).Ghana on Course to Halve Poverty. Available at: [(www.woldbank.org/afr) or (Ghanaweb, general news, Friday,25th May, 2007)]

World Health Organization.[Internet]. WHO definition of health [cited 2009 May, 22]. Available from: (http://www.who.int/about/definition/en/print.html).

WHO, (2011). "Housing and Health" Available at: (http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/urban-health), [Retrieved: July 15, 2012]

WHO, (2002). "Active Ageing: A Policy Framework, Contribution of the WHO to the Second United Nations' World Assembly on Ageing, Madrid: United Nations.

WHO.(2003). *WHO Definition of Palliative Care*.Available from:(http://ww.who.int.).

Wiles, J. (2003). Informal Caregivers' Experiences of Formal Support in a Changing Context:*Health and Social Care in the Community*, 11, (3), 189-207.

Zimmer, L. (2006). Qualitative meta-synthesis: a question of dialoguing with texts. *Journal of Advanced Nursing*, 53, (3), 311-318.

Zimmer, Z., (2006). "Poverty, Wealth, Inequality and Health Among Older Adults in Rural Cambodia":*Policy Research Division Working Paper*, vol. 217.

Zimmer, Z. and Amornsirisomboon, P., (2001)."Socioeconomic Status and Health Among OlderAdults In Thailand: An Examination, Using Multiple Indicators", *Social Science And Medicine*,Vol. 52, No. 8, Pp. 1297-1311.

Zimmer, Z. and Kwong, J., (2004). "Socioeconomic Status and Health among Older Adults in Rural and Urban China", *Journal of Aging and Health*, vol. 16, no. 1, pp. 44-70. Available from: (htt://www.un.org/Pubs/chronicle/200).

htt://www.huduser.org/periodical.

APPENDIX A

DEPARTMENT OF PLANNING

COLLEGE OF ARCHITECTUREAND PLANNING

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

Topic: The Emerging Problems of the Aged: the Issues of Housing and Basic Care

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This research instrument is designed to solicit for empirical data for the conduct of academic exercise on the above mentioned topic for the award of MSc degree in Development Policy and Planning, KNUST. Your support and cooperation is very much anticipated as information given will be treated with absolute confidentiality.

Interview Guide for the Aged

(Tick the Appropriate Option or Write the Response where Applicable at the Space Provided)

Name of Community ……. Date of Interview…….

(A) General Information

1. Age of the respondent.....
2. Sex of the respondent; Male [ ] Female [ ]
3. Marital Status; Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ]
4. Education; Never [ ] Primary [ ] Middle/JSS [ ] Post Sec/SHS/VoTech[ ] Tertiary [ ]
5. No. of persons in household.....
6. How many children do you have? .....
7. How many are below 18 years? …….
8. How many dependants do you have? (mainly for food, clothing, healthcare, school fees)..

(B) **Financial Support**

9. What do you do for a living? …….

10	**Source(s) of income support(tick as many as applicable)**	**Amt Received (GH₵)**
(a)	Children	
(b)	Sibling(s)/relatives	
(c)	Current employment	
(d)	Pensions benefit	
(e)	Rent on property	
(f)	Profit on Investment	
(g)	LEAP fund	

(h) Others (please specify) …….

11.	**How much do you spend on each of the following items per month?**	**Amt. spend (GH ₵)**
a.	Food	
b.	Clothing	
c.	Housing/Rent	
d.	Healthcare	
e.	Utility bills	
f.	Transport	
g.	Church/funeral	

(h) Others (please specify)……

12. Have you formally retire from active service a. Yes [ ] b. No [ ]

13. What kind of employment did you officially retired from? ……

14. Do you still live in the town you were working before official retirement?

a.Yes [ ] b. No [ ]

15. If yes, why did you move? ……

(B) Housing/Living Arrangements

16. What kind of living arrangement are you engaged in? a. Rented [ ] b. Perching [ ] c. Own house [ ] d. Family house [ ] e. Others (please specify) ……

17. Why do you have such a living arrangement? ……

18. Type of toilet facility use? a. KVIP [ ] b. WC [ ] c. Dug out [ ] d. Free range [ ] e. Others (please specify) ……

19. Where do you access it? a. Inside house [ ] b. Other house [ ] c. Public [ ] d. Bush/gutter [ ]

20. Source of water? a. Pipe borne [ ] b. Bolehore [ ] c. Well [ ] d. River/Stream [ ] e. Others (please specify) ……

(C) Social Support/Social Network

21. Who are you living with? a. Spouse [ ] b. children [ ] c. other relative(s) [ ] d. non-relative [ ] e. Others (please specify) ……

22. Is there any contractual agreement between you and your personal help?

(a) Yes (b) No

23. What kind of contractual agreement is it? a. Salary/wage [ ] b. Free care/no payment [ ]

c. Material reward [ ] d. Others (please specify……

24. By what means do you break boredom or reduce/eliminate loneliness? a. Visit friends [ ]

b. Join club/association [ ] c. Move about [ ] d. Others (please specify) ……

(D) Health Conditions

25. How many times do you visit a health facility in a Year? a. Once [ ] b. Twice [ ] c. thrice [ ] d. Others (please specify) ……

26. What kind of illness/sickness do you mostly report to the hospital for treatment?

27. How much do you spend on healthcare per a visit to the hospital/Clinic?

28. What type of healthcare do you mostly seek?

a. hospital/clinic [ ] b. herbal [ ] c. spiritual [ ]

d. others (please specify) ……

29. Why did you choose this type of healthcare? ……

30. How do you finance your healthcare? a. own income [ ] b. health insurance [ ] c. combination of the two [ ] d. others, (please specify)……

31. What do you do to sustain/maintain your health? a. regular exercise [ ] b. balanced diet [ ] c. regular check-up [ ] d. adequate rest [ ] e. Others, (please specify) ……

32. Do you have any physical impairment? a. Yes [ ] b. No [ ]

33. Which of the following health aids do you use? a. Walking Stick [ ] b. Sight [ ] c. Hearing [ ] d. Others (please specify) ……

34. What are some of your major challenges in life as an aged? ……

35. What do you think can be done to solve these challenges?
……

APPENDIX B

Topic: The Emerging problems of the Aged: the Issues of Housing and Basic Care

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Questionnaire for the Institutions

(Tick the Appropriate Option or Write the Response where Applicable at the Space Provided)

1. Name of institution……
2. Respondents status in the institution ……
3. What does your institution do to support the aged? ……
4. What criteria does your institution use in selecting the aged? ……
5. What is your source(s) of funding? ……

Are you aware of any national policy for the aged in relation to:-

6. The healthcare needs of the aged? (a) yes [ ] (b) no [ ]
7. If yes, what is it about? ……
8. The housing needs of the aged? (a) yes [ ] (b) no [ ]
9. If yes, what is it about? ……
10. The financial needs of the aged? (a) yes [ ] (b) no [ ]
11. If yes, what is it about? ……..
12. The social support for the aged? (a) yes [ ] (b) no [ ]
13. If yes, what is it about? ……...
14. How far has these policies helped improved the wellbeing of the aged? ……
15. What does your institution do to support the wellbeing of the aged? ……
16. How will you grade your support to the aged? a. good [ ] b. very good [ ] c. neutral [ ] d. poor [ ]
17. What challenges does your institution face in supporting the aged? ……
18. What do you recommend to be done? ……

APPENDIX C

Topic: The Emerging Problems of the Aged: the Issues of Housing and Basic Care

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Interview Guide for (those who give the AgedSocialsupport) Caregivers

(Tick the Appropriate Option or Write the Response where Applicable at the Space Provided)

Name of Community ……. Date of Interview…….

(A) General Information

1. Age of the respondent.....
2. Sex of the respondent; Male [ ] Female [ ]
3. Marital Status; Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ]
4. Education; Never [ ] Primary [ ] Middle/JSS [ ] Post Sec/SHS/VoTech [ ] Tertiary [ ]
5. No. of persons in household.....
6. How many children do you have? .....

(B) **Financial Support**

7. What do you do for a living? …….

8.	**Source(s) of income support for the aged person (tick/indicate as many as applicable)**	**Amt Received (GH₵)**
(a)	Children	
(b)	Sibling(s)/relatives	
(c)	Current employment	
(d)	Pensions benefit	
(e)	Rent on property	
(f)	Profit on Investment	
(g)	LEAP fund	

(h) Others (please specify) …….

9.	**How much do you spend on each of the following items per month?**	**Amt. spent (GH ₵)**
a.	Food	
b.	Clothing	
c.	Housing/Rent	
d.	Healthcare	
e.	Utility bills	
f.	Transport	
g.	Church/funeral	

(h) Others (please specify)…….

10. What kind of employment did he/she officially retired from? ……

11. Where was the aged person living to work before official retirement? ……

(B) Housing/Living Arrangements

12. What kind of living arrangement are you engaged in? a. Rented [ ] b. Perching [ ] c. Own house [ ] d. Family house [ ] e. Others (please specify) ……

13. Why do you have such a living arrangement? ……

14. Type of toilet facility use? a. KVIP [ ] b. WC [ ] c. Pit latrine [ ] d. Free range [ ] e. Others (please specify) ……

15. Where do you access it? a. Inside house [ ] b. Other house [ ] c. Public [ ] d. Bush/gutter [ ]

16. Source of water? a. Pipe borne [ ] b. Borehole [ ] c. Well [ ] d. River/Stream [ ] e. Others (please specify) ……

(C) Social Support/Social Network

17. What kind of relation are you with him/her? a. Spouse [ ] b. Parent [ ] c. Grandparent/other relative [ ] d. Non-relative [ ] e. Others (please specify) ……

18. Is there any contractual agreement between you and the aged person? (a) Yes (b) No

19. What kind of contractual agreement is it? a. Salary/wage [ ] b. Free care/no payment [ ]

c. Material reward [ ] d. Others (please specify……

20. By what means does your aged person break boredom or reduce loneliness? a. Visit friends [ ] b. Join club/association [ ] c. Move about [ ] d. Others (please specify) ……

21. What kind of support do you offer to the aged person? ……

(D) Health Conditions

22. How many times does your aged person visit a health facility in a Year? a. Once [ ] b. Twice [ ] c. thrice [ ] d. Others (please specify) ……

23. What kind of illness/sickness does your aged person mostly report to the hospital for treatment? ……

24. How much do you spend on healthcare per visit to the hospital/Clinic?.....

25. What type of healthcare do you mostly seek? a. hospital/clinic [ ] b. herbal [ ] c. spiritual [ ]

d. others (please specify) ……

26. Why did you choose this type of healthcare? ……

27. How do you finance the healthcare? a. own income [ ] b. health insurance [ ] c. combination of the two [ ] d. others, (please specify)……

28. What does your aged person do to sustain/maintain his/her health? a. Regular exercise [ ] b. Balanced diet [ ] c. Regular check-up [ ] d. Adequate rest [ ] e. Others, (please specify)

29. Does your aged person have any physical impairment? a. Yes [ ] b. No [ ]

30. Which of the following health aids does he/she use? a. Walking Stick [ ] b. Sight [ ] c. Hearing [ ] d. Others (please specify) ……

31. What are some of the major challenges do you encounter in caring for the aged person?

32. What do you think can be done to solve these challenges? ……

33. What do you see as major challenges that the aged themselves experience? ……..

34. What do you think is the way forward? .....

APPENDIX D

Topic: The Emerging problems of the Aged: the Issues of Housing and Basic Care

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Questionnaire for the Religious Groups

(Tick the Appropriate Option or Write the Response where Applicable at the Space Provided)

1. Name of institution/religion……
2. Respondents status in the institution/religion ……
3. Do you have aged people in your church/religion? a. Yes [ ] b. No [ ]
4. What does your institution do to support the aged? ……
5. What criteria does your institution use in selecting the aged to support them? ……
6. What is your source(s) of funding? ……..

Are you aware of any national policy for the aged in relation to:-

7. The healthcare needs of the aged? (a) yes [ ] (b) no [ ]
8. If yes, what is it about? ……
9. The housing needs of the aged? (a) yes [ ] (b) no [ ]
10. If yes, what is it about? ……
11. The financial needs of the aged? (a) yes [ ] (b) no [ ]
12. If yes, what is it about? ……..
13. The social support for the aged? (a) yes [ ] (b) no [ ]
14. If yes, what is it about? ……...
15. How far has these policies helped improved the wellbeing of the aged? ……..
16. What does your institution do to support the wellbeing of the aged? ……..
17. How will you grade your support to the aged? a. Good [ ] b. Very good [ ] c. Neutral [ ] d. Poor [ ] e. Very poor[ ]
18. What challenges does your institution face in supporting the aged? ……
19. What do you recommend/think is the way forward? ……..

APPENDIXE

Topic: The Emerging problems of the Aged: the Issues of Housing and Basic Care

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Sample Size Determination

The sample size was determined by a mathematical formula given by Miller and Brewer (2003) as; $n = \frac{N}{1 + N(\alpha)^2}$ where **N** isthe sample frame, **n** isthe sample size and $\boldsymbol{\alpha}$ is the margin of

error (fixed at 5 percent).

The sample size, **n** becomes; n= {775/ [1+ 775(0.05) ^{2}]} = 775/2.937 = 263.87 = 264.

The aged who were interviewed were proportionally selected from the communities and per mathematical calculation (P x n/N) where "P" is population of the aged, "×" is multiplication sign, "N" is sample frame, "/" is division sign and "n" is sample size. The simple proportional formula which was used to calculate for the number of aged interviewed in each selected Community/zone weredefined as follows; Sample Frame (SF) α Sample Size (SS); where α is a proportionality sign. The constant of proportionality then becomes the initial values of SS/SF. The number of aged to be selected for interview from each community/zone will be calculated as;

If 775 α 264, then;

Bomso Community/Zone (101) = 264/775 × 101 = 34 Aged in Bomso community/zone.

Oforikrom Community/Zone (160) = 264/775 1×60 = 55 Aged in Oforikrom community/zone.

Anloga Community/Zone (124) = 264/775 × 124= 42 Aged in Anloga community/zone.

Jachie Community/Zone (150) = 264/775 × 150 = 51 Aged in Jachie community/zone.

Kuntenase Community/Zone (125) = 264/775 ×125= 43 Aged in Kuntenase community/zone.

Apenkra Community/Zone (115) = 264/775×115 = 39 Aged in Apenkra community/zone.

Table 3.5 shows the sample frame and the sample size of the selected communities /zones in the study area.