AGEING AND CHRONIC DISEASES IN GHANA: THE CASE OF AKIM ODA

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DECLARATION

I, Kyei Baffour Asante, do hereby declare that, this work is the result of my own original research, and that this dissertation, either in whole or in part, has not been presented elsewhere for another degree. It has been undertaken by my own efforts under the supervision of Dr. Abena Ampomah and Dr. Emma S. Hamenoo of the Department of Social Work, University of Ghana, Legon.

Full acknowledgements have been given in places where reference is made to people’s work.

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ABSTRACT

The study explored the issue of ageing and chronic diseases by looking at the types of chronic diseases, contributing factors, challenges and coping strategies of the elderly. The elderly are among the groups most vulnerable to chronic disease worldwide. The prevalence and associated risk factors for these chronic diseases have been observed to have increased over time in Ghana, including Akim Oda. The views and opinions of 19 elderly persons between the ages of 60 and 90 years receiving treatment from Akim Oda Government Hospital were solicited with four key informants. Data was collected through in-depth interview and analysed following Attride-Stirling’s (2001) thematic analysis using NVivo 11. Four main types of chronic diseases identified in the study were hypertension, diabetes, stroke and AIDS. According to study participants’ understanding, chronic diseases like diabetes, hypertension and stroke are caused by excessive alcohol consumption, physical inactivity, and emotional, psychological or stress-related trauma. The findings further revealed that challenges encountered by the elderly living with chronic diseases include high cost of health care. Other challenges include social challenges such as loss of vision, limited mobility, sexual weakness and inability to shoulder responsibility. The findings also revealed challenges such as neglect by family members and delay in reporting to hospital. This study concludes that the elderly in Akim Oda employ the use of the media (listening to preaching, watching children programmes), change in lifestyle behaviour (adhering to prescribed medication and food), and drawing on faith and the support of spouses, siblings and children as strategies to cope with the biographical disruptions they experience. This study concludes that there are different biographical disruption experiences among the elderly in Akim Oda and the precise impacts of these experiences on the lives of the elderly influences the kind of strategies they adopt to manage their health, social and economic conditions. Social workers are to encourage individuals to save during their youthful years and to maintain healthy family ties.
CHAPTER ONE
BACKGROUND OF THE STUDY

1.1 Introduction

Population ageing is a well-recognized global phenomenon (Bowling, 2007). The section of the population aged 60 and over is growing faster than any other age set in the world, and the ageing of the population remains both a success and a challenge for public health (World Health Organization, 2002). It is projected that by 2025 there will be about 1.2 billion people over 60 years of age. By 2050 they will reach 2 billion, of which 80% are in developing countries, including Ghana (WHO, 2002). The United Nations (2003) also reports that the number of people aged 60 and over has grown significantly in recent years in most countries and regions, and that the increase in elderly population will accelerate in the coming decades.

The population aged 60 and over increased from 200 million in 1950 to 600 million in 2000; in 2006, the number of elderly persons exceeded 700 million, and current projections suggest that, in 2050, there will be 2 billion elderly people alive. In other words, their number will triple in 50 years (Mba, 2003). According to the National Institute of Ageing (NIA) in 2007, in 2006, nearly 500 million people in the world were 65 years of age or older. By 2030, it is expected that this total will increase to 1 in 8 people on the planet. Significantly, the fastest increases in the population aged 65 and over occur in developing countries, including Ghana, which will see a 100% increase by 2030.

In sub-Saharan Africa, the estimated elderly population (60 years and over) will exceed 10% of the total population by 2050. The number of elderly aged 60 and above in Africa is expected to surge by more than 63% by 2030 (United Nations, 2002). The ageing of the African population is expected to increase rapidly between 2010 and 2030, as more and more people turn 65, and projections show that elderly could represent 4.5% of the population by 2030 and almost 10% of the population by 2050 (Nabalamba et al., 2009). This
increase in the ageing of the population will have a profound impact on labor markets, health, aggregate demand, politics and social structures. Nabalamba et al. (2009) reported that in 1980, 3.1% of the African population was 65 years of age and older and had increased steadily over the last forty years. According to the same report, as of 2010, 36 million elderly persons were 65 years and above, accounting for 3.6% of the population—an increase of 3.3% in ten years.

Elderly persons, as defined by the Ghana Statistical Service (GSS), are people aged 60 years and over (GSS, 2013). In Ghana, the population of the elderly has increased sevenfold since the 1960 census, from 213,477 in 1960 to 1,643,381 in 2010 (GSS, 2013). A greater percentage of the older population (54%) are from rural areas, while 47% of women and 44% of men live in urban areas (GSS, 2013). In Ghana, the elderly population is expected to nearly double from 6% in 2013 to 12% in 2050 (Yawson, 2015).

Ageing is continually viewed as a negative step in the life cycle of humanity, in which there is a great need for support, as there is a cognitive deterioration and perceived diminished quality of life (GSS, 2013). In this study, the researcher used the functional age groups: 60-74 ages (young-old), 75-84 ages (old-old) and above 85 (very old) as reported by the Population and Housing Census of 2010 in Ghana (GSS, 2013). The increase in the ageing of the population, which is common in developed countries, also occurs in developing countries, including Ghana. Globally, there are eight hundred and ten million people who are sixty years and above, representing 11.5% of the world’s population of 7 billion (GSS, 2013).

The ageing process exposes elderly persons to an increased threat of chronic disease and infirmity (WHO, 2010). Ageing is associated with brittleness and the appearance of chronic diseases (Mba, 2006). An estimated 57 million deaths worldwide were recorded in 2008 and 63% of them were due to chronic diseases, mainly cardiac diseases, diabetes, cancers and chronic lung diseases (WHO, 2010). In addition, most of the deaths due to
chronic diseases (80%) occurred in low- and middle-income countries, such as Ghana, and these conditions prevail at Akim Oda. The WHO predicts that the number of deaths from chronic diseases will increase by 15% worldwide between 2010 and 2020, resulting in 44 million deaths (WHO, 2010). Yach et al., (2004) estimated that chronic diseases will be the principal cause of death worldwide by 2025 and that the least industrialized countries in Africa, Asia and Latin America are the most affected by this increasing international burden of chronic disease. Murray et al., (1996) argue that people seek medical care in developed countries mainly because of chronic disease. Ghana is one of a number of countries in sub-Saharan Africa experiencing an epidemiological transition where chronic diseases are increasing, including among the elderly population. As in other global contexts, the increase in chronic diseases and mortality from chronic disease has been attributed to urbanization, nutritional transition and the effects of globalization (Aikins et al., 2012). Elderly people in Ghana are prone to chronic diseases that affect them for the rest of their lives (GSS Report, 2013). Awareness and knowledge of these chronic diseases is limited; health systems are weak; and the Government has no specific chronic disease policies, resulting in increased risk, morbidity, and mortality (Aikins et al., 2012). In a 2003 Ghana chronic disease burden analysis, Aikins reported that hypertension, stroke, diabetes and cancer are now among the top ten chronic diseases reported in Ghana (2007). Diabetes, hypertension, and stroke are suffered by both young and elderly, urban and rural, rich and underprivileged populations (GSS, 2013).

In Ghana, the number of older persons is increasing, but optimal attention has not been paid to the health and care of this segment of the population. In 2010, the Ministry of Employment and Social Welfare (MESW) launched its national ageing policy (first developed in 2002), but the policy does not comprehensively cover chronic diseases. The policy recognized health, living environment, and gender equality as three of the top seven
challenges faced by the elderly in the country. The policy document proposes to improve the health, nutrition, well-being, housing and living environments of older people, and to give sufficient attention to overcoming these challenges (MESW, 2010). While the policy represents a crucial first step in directing much-needed public attention to the ageing population, there are many challenges to implementing it. First, budget allocations to support planned activities for the ageing population are insufficient. In addition, the paucity of data at the national level is an inhibiting factor for the provision of specific interventions with limited national resources (MESW, 2010).

Health systems in Ghana are poorly fortified to cope with the dual burden of infectious and chronic diseases, and, although diabetes, hypertension and other chronic diseases have been a priority in authorized documents since the early 1990s, the chronic disease policy or plan has not been transformed into tangible action (MESW, 2010).

1.2 Statement of the Problem

Ageing is associated with greater vulnerability to health problems for most elderly persons, and chronic diseases increase the risk of illness and disability. Some older people will experience unexpected and rapid deterioration of their health, while others will progressively degenerate for many years, and others still will experience episodes of illness and frailty due to chronic illness. The extraordinary financial cost of chronic disease care can lead to impoverishment, placing additional stress on the health and well-being of an already ailing body. The growth of the elderly population makes chronic diseases associated with ageing an increasingly a problem. If nothing is done to improve the situation of older people living with chronic diseases, Ghana’s challenges as a developing country will deepen. Furthermore, without access to improve quality of life throughout their lifespan, many Ghanaians may arrive at old age with chronic illness (Mba, 2010). Tinker argued that "ageing and illness is a bed follow:" with increase in age, the effectiveness of the immune system is
reduced, and this affects resistance to diseases, including cancer and stroke, and rheumatic, cardiac and pulmonary diseases (Tinker, 1984). According to Wan et al., (2015), when the global populace reached 7 billion people in 2012, 562 million (or 8.0%) were 65 or older and researchers argued that this is due to increasing life expectancy caused by several factors such as improved health facilities and availability of medicines (United Nations, 2002). Three years later in 2015, the populace had grown to 55 million, and the percentage of the elderly population was 8.5% of the entire populace.

Ghana’s health policies (for example, ageing policies and national plan for health insurance) do not offer comprehensive coverage for chronic diseases often connected with the elderly. Chronic diseases create additional stress that forces older people to develop new coping methods. Although ageing itself is associated with weakness, the onset of chronic diseases deteriorates the situation of the elderly (Mba, 2010).

Whether through emerging infectious diseases or the changing climate, we live in a time of unpredictable health problems, but one trend is certain: the elderly population is growing rapidly worldwide (WHO, 2002). For the first period in history, most people can expect to live to age 60 or older, and this increase in life expectancy is leading to a general ageing of the world's population (WHO, 2006). According to UN (2003), by the middle of this century, the elderly population in the world will outstrip the number of young persons, for the first time on record. This population shift is expected to make chronic disease a major public health challenge. The percentage of deaths from chronic diseases among the elderly over 60 years old will exceed that of transmittable diseases, maternal and prenatal diseases, and nutritional insufficiencies that cause severe life and livelihood disorders (WHO, 2005).

The deterioration in well-being connected with chronic diseases often leads to stress-related problems in elderly people (Kagee, 2010). Chronic diseases create additional stress that forces elderly to develop new forms of adaptation (Morris et al., 2011). Chronic diseases
increase medical costs and reduce the labor productivity of older people. Chronic diseases account for 75% of total health expenditures of the United States of America (WHO, 2010).

World Health Organization (2010) also identified that each year 100 million elderly persons are plunged into poverty because they have to pay directly for health services: this represents 5% of the population in some countries, particularly in developing countries, who are forced to live in poverty every year.

Naturally, though every elderly person will ultimately face deteriorating health and functioning, their precise health paths might differ considerably, and the appearance of chronic diseases in the lives of older people makes them even more vulnerable (WHO, 2015). The presence of these health conditions has a substantial influence on an elderly person’s life with little or no support (MIPAA, 2007).

Nevertheless, there appear to be limited studies on ageing and chronic disease in Akim Oda, where the present study was conducted. Given the scarcity of studies in this regard, this study examines issues of ageing and chronic diseases by looking at the types of chronic diseases, contributing factors, challenges and coping strategies of the elderly in Akim Oda, Eastern Region of Ghana.

1.3 Objectives of the Study

This study explored issues of ageing and chronic diseases by looking at the types of chronic diseases, contributing factors, challenges and coping strategies of the elderly in Akim Oda. Given the abovementioned context in which the present study is situated, the following specific objectives were pursued:

1. To identify the types of chronic diseases elderly persons experience in Akim Oda.

2. To explore the factors that contributes to chronic diseases in elderly persons in Akim Oda.
3. To examine the challenges encountered by elderly persons living with chronic disease in Akim Oda.

4. To ascertain the coping strategies adopted by elderly persons suffering from chronic diseases in Akim Oda.

1.4 Research Questions

The following exploratory enquiries directed the conduct of the study:

1. What types of chronic diseases do elderly persons experience in Akim Oda?
2. What factors contribute to chronic diseases among elderly persons in Akim Oda?
3. What are the challenges faced by elderly persons living with chronic diseases in Akim Oda?
4. What are the coping strategies adopted by elderly persons experiencing chronic diseases?

1.5 Significance of the Study

The significance of the study was discussed under three main topics, namely: policy, research, and practice.

1.5.1 Policy

The findings can be used to guide policymakers in Ghana in improving policies and programmes on the welfare of the elderly to make them more effective. The country’s existing ageing policies should be reformed to make provisions for chronic diseases. An in-depth look at the experiences of aged chronic disease sufferers will give Government and interested non-governmental organisations (NGOs) insight into how existing policy and implementation affect real people, helping them to develop innovative solutions to the challenges facing the aging nation.
1.5.2 Research

There is scant literature on chronic disease among elderly persons in Ghana. This study will therefore supplement available literature on elderly and chronic disease in Ghana and illuminate areas needing further research. Findings of the study are expected to serve as a foundation for larger scale research on elderly and chronic disease in Ghana.

1.5.3 Practice

The findings would have implications for social work practice by informing social work practitioners on the issues of elderly and chronic diseases in Ghana. The study enabled the researcher to gather personal quality-of-life accounts from older people with chronic diseases, which could be useful in building holistic care and treatment practices. Findings also stress the need for practical support, legal advice and information on available support services and the need for families to provide care and support to elderly persons. The general public will be educated through article(s) to be published from this work on chronic diseases of the elderly. The final report will indicate factors that influence their quality of life, including services and programmes.

Findings and recommendations will help stakeholders to improve upon practices and will serve as a foundation for more widespread research on ageing and chronic disease in Ghana. The findings will have implications for social work practice by informing social work practitioners on the issue of ageing and chronic disease in Ghana. Social workers will also be encouraged to include ageing and chronic diseases in their educational programmes.

1.6 Justification of the Study

According to the WHO (2010), chronic diseases, such as stroke, cancer, and chronic lung diseases, heart diseases and diabetes, are the foremost sources of death in the world: 56 million deaths globally in 2012 were triggered by chronic diseases. The population on the African continent will age swiftly in the coming years, mainly because of the decline in
mortality rates. The volume of people aged 60 and above is projected to quadruple from 45.7 million to 182.6 million in 2050 (UN, 2005). It is interesting to note that while chronic diseases account for 68% of deaths worldwide, they have been found to account for 80% of all deaths in developing countries, posing a significant threat to socioeconomic development. In the international community, however, this has not been treated as an issue requiring urgent attention (WHO, 2012).

In sub-Saharan Africa, the southern region will experience the fastest growing ageing population, while the largest number of older people—51.6 million—will live in West Africa by 2050. In West Africa, the ageing of the population will be more pronounced in Nigeria and Ghana (UN, 2005). While Ghana will experience the largest increase in the elderly population, Nigeria will have the largest impact in terms of absolute numbers. Currently, half of the elderly population in West Africa live and will continue to live in Nigeria, increasing from 6.4 million to 25.5 million by 2050 (UN, 2005). While increasing expectations for older persons' survival marks an important achievement for humankind, the elderly continue to struggle with chronic diseases. The fragile nature of older people with chronic conditions indicates an interaction between the biological, psychological and social changes associated with ageing (Claver et al., 2013).

To reach old age is an achievement desired by all people around the world, whether rich or poor, employed or unemployed. As soon as one enters the world, the ageing clock begins to tick, yet those who have already reached old age often struggle to fend for themselves in a society that does not approach elder care holistically. The health of the aged population is a woefully under-researched topic, particularly in developing countries, and especially in Ghana and Akim Oda, where this study was conducted.

The growing burden of chronic diseases affecting older persons is weighing heavily on the health care system, due to increased demand and access to health services. Therefore,
an intensive and coordinated effort is needed to develop strategies aimed at the avoidance and management of these chronic conditions, particularly among the socio-economically disadvantaged populations (Peltzer et. al., 2013). Again, one can find culpability in the many corrupt practices in this part of the developing world for the uncertain future that everyone fears. Old age is a stage of life whose events are highly unpredictable and about which everyone speaks with mixed feelings.

Old age is associated with vulnerability, including increased risk of chronic disease, and a greater need for social services and social protection (MESW, 2010). It is believed that, if appropriate policies are put in place to ensure the well-being of the elderly, their overall quality-of-life would improve regardless of socio-economic status, both at the national and local levels. This would help dispel public fears about the uncertainties of the future and reduce preventable deaths in this age group. A thriving elderly population and robust care services for chronic disease sufferers would contribute to the overall development of the nation. As a result, the research explores issues of ageing and chronic disease by looking at the types of chronic diseases, contributing factors, challenges, and coping strategies of the elderly in Akim Oda.

1.7 Organization of the Study

The study is organized under five main chapters. The first chapter is an introduction, detailing important background information, statement of the problem, objectives, and research questions. Included in this part are the significance of the study, justification of the study and definition of terms. Chapter two consists of the literature review and the theoretical framework. Chapter three covers the research methodology. These include the research design, the sampling technique, sample size, target population, study population, data collection methods, data handling and analysis. The chapter also includes ethical considerations and limitations of the study. Chapter four presents the findings of the study, as
well as the discussion of findings. Finally, the demographic information of study participants, summary of the findings, conclusion, recommendations, and implications for social work practice are discussed in chapter five.

1.8 Definition of Terms

**Elderly Person**

An elderly person refers to a person aged 60 years and above (Ghana Statistical Service, 2013).

**Chronic diseases (CDs)**

CDs are well-defined as diseases or conditions that affect people over an extended period and for which there is no known causal agent that can be transmitted from one affected person to another (Daar et al, 2007). Chronic illness refers to conditions that last more than 6 months and may be accompanied by residual functional deterioration requiring long-term management.

**Ageing**

Ageing is a multidimensional physical, psychosomatic and social transformation (Bowen and Atwood 2004). Sometimes differences are made between the elderly populations such as the young-old (65 to 74 years old), the mid-old (75 to 84 years old) and the oldest old (85 year and above). However, one problem with age groupings is that sequential age does not correspond perfectly to functional age (i.e. two individuals may be of similar age, but different mental and physical abilities) (Bowen and Atwood, 2004).

**Communicable Disease**

A communicable disease is a medical condition which by definition is infectious and transmissible between persons (Daar et al, 2007).
Non-Communicable Disease A non-communicable disease (NCD) is a medical condition which by definition is non-infectious and non-transmissible between persons (Daar et al, 2007).
CHAPTER TWO
REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK

2.1 Introduction

This part reviews the appropriate empirical literature. The chapter is divided under six main themes. The main themes are ageing and chronic disease, type of chronic diseases, factors that contribute to chronic diseases, challenges encountered by elderly persons living with chronic diseases, and coping strategies adopted by elderly persons living with chronic diseases.

2.2 Ageing

The ageing of the population is an unavoidable consequence of the demographic evolution, leading to an upsurge in the percentage of elderly persons in most countries of the world (UNFPA, 2002).

Demographic experts have amassed evidence of the ageing of the world's population (Kinsella, 2001; Peterson, 1999; United Nations, 2002; Strydom, 2008). It is said that the trend is faster in developing regions in Africa (Help Age International, 2008; Mbamaonyeukwu, 2001). It is expected that the African population aged 60 or over will reach 200 million by 2050 (HAI, 2008), and the sub-regions of North and West Africa have the highest proportions of elderly population (Apt, 2007, & United Nations, 2003). Issahaku and Neysmith (2013) claimed that older people in the West African sub-region are concentrated in rural regions, and most are women with minimal or no formal schooling, without formal employment and therefore without retirement allowance. This makes them more vulnerable, and some become a burden for their families and society.

In West Africa, the population is ageing later than that of many other “older” countries (Issahaku and Neysmith, 2013). Recognizing that ageing in West Africa will require local resolutions to local complications, there are lessons to be learned, models to deliberate, and
opportunities to discuss as the country constructs its policy framework and plans programs to meet local requirements. Finally, Issahaku and Neysmith (2013) maintained that governments should not only protect the health, housing and incomes of older people in West Africa, but also pay attention to other issues that affect the well-being of the elderly, including age segregation, non-formal education, employment, politics and social involvement.

Moreover, in Ghana, the proportion of elderly people (60 years and over) increased from 5.2% in 1960 to 7.2% in 2000 (Mba, 2007), declining slightly to 6.5% in 2010 (ESG, 2012). The increasing proportion of older people is due to advances in public health, medical and economic improvements, and the impacts of new technologies on diseases and injuries (Kinsella and Philips, 2005). As a result, the United Nations has recommended that member states establish national policy frameworks to address ageing and chronic issues to ensure that older people lead decent and satisfying lives (UN, 2002).

The Ghana Statistics Service (2013) examined the characteristics of older people in Ghana based on the 2010 Population Census and Housing. Data and other information from pre-independence censuses (1960, 1970, 1984 and 2000) and other secondary sources were also used. Citing demographic trends in Ghana, the bureau concluded that population ageing will continue in the 21st century, with women outnumbering men. The GSS (2013) analysis shows that Ghana’s ageing population has been growing rapidly over the past two decades and will continue, with increasing numbers of Ghanaians surviving to age 60 or older and impacting the use of health systems.

In all population health studies, age almost always appears as the strongest indicator of the health of individuals and the risks of disease and death they face. The precise mechanisms affecting age and wellbeing, however, are not straightforward but abundant and multifaceted (WHO, 2015). Biological ageing is linked with amassed cell impairment that ultimately deteriorates the immune system, reduces the body’s ability to repair itself, and
increases the risk of manifesting a variety of different illnesses (Steves et al., 2012; Vasto et al., 2010, Beard and Bloom, 2015). A person's age is also related to the amount of time they may have been exposed to various exterior health hazards, the effects of which amass over time, such as smoking or poor-quality diet. In accumulation, the social changes that frequently happen as people reach older age, such as vagaries in social functions and the loss of close relations, can pose further hazards to well-being (WHO, 2015).

2.2.1 Health Implications of Ageing

The ageing of the world's population, and therefore an increase in expenditure on well-being and social fortification, is perceived as a menace to worldwide economic stability in the 21st century (Prince et al., 2015). The global epidemic of chronic diseases is firmly connected to the ageing of the populace, and, according to Prince et al. (2015), 23% of chronic illness worldwide arises in the elderly. The main diseases are cancer, chronic lung diseases, musculoskeletal diseases, mental illness, cardiovascular disease, and nervous maladies. In African countries, issues related to ageing have little priority in many areas of government (Mkai et al., 200). This low importance may be due to lack of data appropriate to the population and its condition (Apt, 1997). The ageing of the population poses major challenges in the health system, including rising costs, inadequate forms of service delivery, and difficulties of chronic disease prevention (Ghana Health Service, 2003). The Ghana Health Service (2003) noted that hypertension affects nearly one in five Ghanaian adults. The Ghana Demographic and Health Survey 2008 shows that 1 in 10 Ghanaian women are malnourished and 3 out of 10 women are overweight or obese (GSS, 2009). As a result, some people in Ghana become susceptible to high blood pressure due to obesity and unhealthy lifestyles (GSS, 2009). Yach & Alabama (2004) elucidated that "diabetes causes disruptions in the body, social uniqueness, family/social relationships, economic circumstances and
nutrition." This finding is important in the context of vulnerable older adults in the later stages of life.

Along with underprivileged countries in Latin America and Asia, Africa has a substantial proportion of the overall burden of chronic diseases (Aikins et al., 2010). According to Aikins et al. (2010) over the next ten years, it is expected that the African region will experience the largest increase in mortality rates from cancer, diabetes, and cardiovascular diseases.

2.3 Chronic Diseases

According to the Australian government (2012), chronic diseases are long-term conditions that do not happen spontaneously and from which people rarely recover totally. Chronic conditions are multifaceted and varied in nature, with vast and varying influence on persons and societies. In international usage, the word "chronic disease" is distinguished from transferable or infectious diseases (Whyte, 2012, 65). However, the present study investigated both communicable and noncommunicable chronic diseases. Cancer, stroke, type 2 diabetes, respiratory disorders, and heart diseases like hypertension are all examples of non-communicable chronic diseases (Daar et al., 2007). Epilepsy and sickle cell disease also non-communicable chronic diseases. HIV/AIDS is the most commonly discussed communicable chronic disease. The impact of these chronic diseases on health is twofold: some chronic diseases are responsible for premature death; others result in eternal frailty (Whyte, 2012).

2.3.1 Chronic Conditions among the Elderly

Epidemics of chronic diseases take decades to be fully recognized, although they have origins in early life stages (WHO, 2005). Some of these conditions exist jointly in an individual as comorbidities and are associated with poorer outcomes, higher cost of medical care, and, possibly, more difficult access to medical care (Nimako, 2012). Nimako (2012) reported that most of the available information on comorbidities was compiled from work
done in developed countries around the world. The prevalence of comorbidities has often been studied, for example in Europe, Australia and the United States. In India, it was reported that in 2003, 83% of older people had more than three chronic diseases (Khanam 2011). The same study reported that in China, 21.7% of elderly people living in rural areas had at least two diseases and that 15.9% had at least three diseases.

There is strong evidence that many chronic diseases become more severe with age, although some progress more rapidly than others (Marengoni et al., 2008). In addition, some chronic diseases are more likely than others to be combined with incapacitating conditions and, as a result, produce different patterns that require support for daily routines (Moore et al., 2011). With respect to prevalence of chronic diseases among the elderly, the same study in Canada found that a large majority of people over 55 (72% for men and 78% for women) experience at least one chronic disease, while 27% of men and 33% of women experience three or more diseases. In addition, the study indicated that 34.7% of arthritis patients over 55 years experienced hypertension and 25.2% experienced stroke. The authors also offer a reminder that not all chronic diseases have the same propensity to worsen with age.

A quantitative study by Shaw and colleagues (2010) in India found that the overall pervasiveness of diabetes in adults aged 20 to 79 represented 6.4% of that population, affecting 285 million people in 2010. That number is expected to reach 7.7%, or 439 million adults, in 2030. Between 2010 and 2030, the research revealed that diabetes will increase by 69% in developed countries and 20% in developing countries (Shaw et al., 2010). The findings of the study show that this predicted forecast suggests an increasing burden of diabetes. For example, in Ghana, the prevalence of diabetes in 2010 was 3.6% and is expected to increase significantly if it is not controlled. A survey study of global estimates of diabetes showed that 366 million people had diabetes in 2011. That number is anticipated to reach 552 million by 2030 (Whiting et al., 2011). Depression in the elderly mainly affects
people with other chronic diseases and cognitive disorders (Alexopoulos, 2005). Studies by Raul and Sagare show that spousal loss, retirement, current health status and living in a nuclear family system are determinants of depression and other chronic diseases associated with the elderly population (Raul & Sagare, 2013).

Qualitative research by Mokhtari et al. (2013) suggests that chronic conditions, such as depression, left untreated can reduce quality of life and create suicidal tendencies. According to Tian et al. (2012), depressive symptoms have major adverse effects on patients’ motivation and ability to seek medical care, but some with depressive symptoms may seek medical attention because of physical discomfort. A meta-analysis by Song et al. (2014) has shown that among chronic diseases, depression is one of the commonly misdiagnosed diseases. In addition to improving physical fitness through practice of the Pilates method, social support programs for the elderly must be put in place to ensure their well-being. Public awareness of risk factors will help design effective and appropriate strategies to prevent depressive disorders in older people (Raul & Sagare, 2013).

Aikins (2007) conducted a qualitative study in Ghana and explained that poverty seems to be one risk factor for infectious diseases and long-term illnesses. Likewise, studies in poor communities in Accra since the 1970s have revealed a large number of known and persistent diseases in contrast to rich communities. Aikins (2007) added that it is possible that these poor communities suffered from complications and died prematurely of chronic diseases because they did not have access to quality medical care.

According to the World Health Organization (2008), diabetes and hypertension are two of the primary public health difficulties that can cause about one million untimely deaths globally. In South Africa, population-based research also revealed that blood pressure in black women living in urban areas are higher than in other tribal groups (Mkhonto et al., 2012). The spread of blood pressure also increases in rural areas (Mkhonto et al., 2012).
According to Cooper et al. (2011), taking care of chronic illnesses such as high blood pressure requires initial diagnosis. This is especially important for elderly in Africa, especially in rural communities, who may not be aware of their illness. The knowledge of the elderly in most African communities is considered poor, and their health beliefs are deeply integrated into the social and cultural skills systems that prevail in their society (Aikins et al., 2010).

### 2.3.2 Health Seeking Behaviour among Elderly Persons Experiencing Chronic Diseases

Grover et al. (2006) studied socio-demographic determinants of treatment-seeking behaviour among symptomatic breast cancer patients in northern India. The authors found that looking for care is an essential theme in all types of diseases since the duration of symptoms increases the likelihood of developing severe illness. Looking for care was considered an interlude: it takes time to evaluate the problem and time to act on the choice to pursue care.

In a cross-community study conducted by Rahman et al. (2011) on "Health and Disease Behaviour Pattern in Rural Bangladesh," the authors found that fever was the most commonly reported symptom, followed by gastric diseases, including dysentery, and respiratory diseases. In the situation of intestinal syndromes, nearly two-thirds of those surveyed used qualified allopaths followed by paraprofessionals. Two-thirds of people received treatment for the pain and discomfort from a certified allopath, while 16% went to an uncertified allopath. For lung difficulties, 70.5% of those surveyed were treated by a certified allopath, while 13.6% sought treatment from an uncertified allopath. In another study by Chakraborothy (2005) on "behavioural health research of the elderly population of a rural block in West Bengal," the author noted that 90% of older people, regardless of sex, consult a doctor, 90% of whom were allopathic and 10% Ayurvedic/homeopathic. Recognition of the disease and the response of the affected person, including changing health
providers, depended on a number of factors such as age, literacy, poverty, social activity, disability, state of health, marriage and socio-economic class.

In a study of gender and rural-to-urban disparities in self-reported chronic diseases and the health risks of older people in Ghana, Yawson et al. (2015) indicated that women made up a greater proportion of elderly urban residents, while men made up the majority of older people in rural areas. In addition, the proportion of young adults was higher in urban areas. Sexual differences exist in older people in urban and rural areas. The analysis revealed obvious disparities in the prevalence of certain health risks: alcohol and tobacco consumption was more prevalent in rural areas, while obesity was higher in urban areas. Urban residents had higher rates of self-information for the eight chronic diseases. For example, urban dwellers’ awareness of hypertension was three times higher than the awareness in rural areas. In his review of hypertension surveys by population in Ghana in 1973-2009, Addo and colleagues showed that 54.6% of urban dwellers had access to information on hypertension, compared to 19.3% of people living in rural areas (Yawson et al., 2015).

2.4 Types of Chronic Diseases among the Elderly

A quantitative study by Kalavathy et al. (2010) in India on chronic disease among the elderly, comparing urban, provincial, and coastal settlements in Kerala, found that hypertension was the most common non-perceived ailment across all zones. The degree of disease perception differs substantially among the zones, with coastline districts showing the highest degree of chronic illness perception. The disease perception level in urban areas was 8.08%, with 11.42% in rural areas, and 21.4% in beach front zones. The perceived disease burden of chronic obstructive pulmonary diseases and diabetes was more significant than that of all other diseases; the difference in disease perception among the zones was more significant for arthritis. Chakrabarty and Alabama (2010), considered debilitating illness and chronic conditions among geriatric occupants in a rural community in India. Out of 495 study
participants, 80 were practically debilitated and unable to carry out tasks of everyday life, and the majority had three or more chronic diseases. 92.5% of the participants examined had one or more chronic diseases.

Adoma et al. (2014) studied ageing and chronic diseases in Ghana and distinguished two broad categories of chronic disease. These were heart-related chronic diseases (CDRS) and non-heart-related chronic diseases (NHRCRD). Of the considerable number of ailments, hypertensive heart disease was the most widely recognized, representing half of the cases. The instances of diabetes and cancer were comparable in 2004 and 2009. Instances of stroke and chronic respiratory diseases were the least reported chronic diseases in the elderly.

Notwithstanding persistent challenge of parasitic sicknesses, chronic diseases have been recognized as a major medical issue in developing nations (WHO, 2005). Ghana Health Service (2003) documented that hypertension affects almost one of every five Ghanaian adults. The Ghana Demographic and Health Survey 2008 demonstrates that 1 out of 10 Ghanaian women are malnourished and 3 out of 10 women are overweight or obese (Ghana Statistical Service ESG, 2009). That is, obesity shows a higher prevalence (30.0%) than malnourishment (9%) among women in Ghana. Therefore, some fall victim to hypertension resulting from obesity and unhealthy lifestyles (Micah et al., 2004).

A study led by Deenadayalan (2011) on medical services in Tamil Nadu (South India) uncovered that the predominance of morbidity in the elderly was around 29%. The majority presented with just a single sickness. The principal diseases in urban regions were diabetes mellitus, hypertension, stroke and heart diseases, while provincial regions showed joint and bone issues, diabetes mellitus and hypertension. In general, subordinate elderly individuals were more likely to attempt to deal with their ailments compared to non-subordinate people. Persons who were not completely dependent became more likely to seek healthcare after
consideration. More established elderly women preferred care-seeking behaviour over more elderly men. Individuals with only asthma or hypertension were liable to seek treatment.

The 2011-2012 Australian Health Survey (AIHW) information demonstrates that around 15% of the populace have joint pain, 13% with back disorders, 10% with hypertension, 10% have asthma and 10% struggle with depression. General physicians report that the most well-known chronic diseases or ailments they encounter are hypertension, diabetes, and arthritis, joint pain and stress issues, particularly hypercholesterolemia. An ongoing worldwide study demonstrated that in Australia and New Zealand, chronic diseases represent 85% percent of the total disease burden and 90% of the mortality burden (IHME 2013). In any case, death rates related to certain chronic diseases appear to have increased in Australia, particularly cardiovascular diseases and some cancer-like growths (AIHW 2014).

2.5 Factors That Contribute to Chronic Diseases among the Elderly

Chronic diseases are often discussed in relation to four major disease groups: cardiovascular, cancers, chronic obstructive pulmonary diseases (COPD) and diabetes, with four primary behavioural risk factors including physical inactivity, smoking, poor nutrition and harmful use of alcohol (AIHW 2014). Chronic diseases are the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths in 2011 (AIHW 2010). The chronic infectious disease issue was recorded in comparison with acute infectious diseases in the late 19th and early 20th century. Despite changing ways of life and ageing of the population, chronic diseases have become increasingly common and are now the key burden among health problems.

As indicated by Mba (2010), the increased elderly population (populace matured 60+ years) around the globe is a testament to improvements in physical living conditions, decreases in infant, child and maternal mortality, enhanced sustenance, decrease in parasitic ailments, and institutional improvements in healthcare, education, and income. As specified
by Aikins et al. (2010), Africa's constant chronic disease load is attributable to multiple and diverse causes, including a surge in life expectancy, lifestyle improvements, poverty, urbanization and globalization. The World Health Organization (2006) has recommended that chronic illnesses, for example, continuous pulmonary disorders (identified with cardiovascular ailments and musculoskeletal ailments) are the third leading cause of death, placing a notable weight on health insurance frameworks around the globe. The normal hazard factors are air contamination, ageing, respiratory diseases, bronchial asthma (BA), low financial status, and smoking (Mirrakhimov, 2012).

Geoppel et al. (2015) evaluated general wellbeing for elderly persons aged 50 years or more diagnosed with chronic disease in China, Ghana, India, Mexico, the Russian Federation and South Africa. Their study population included 16,631 people who formed a globally representative sample. Geoppel et al. (2015) uncovered that the prevalence of analyzed chronic conditions in individuals aged 50 years or more differed widely among the six nations under examination and was higher in the more developed and more urbanized regions. This might be because of the negative wellbeing effect of life changes associated with modernization (Geoppel et al., 2015). None of the six nations provided access to fundamental care for chronic disease to the majority of their citizens. In other words, the research showed significant gaps in basic health administration for chronic illnesses in low- and middle-income nations (Geoppel et al., 2015).

Disparities in healthcare inclusion in middle income nations, which have been documented in numerous studies, persevere despite significant changes to healthcare provision aimed at enhancing inclusiveness, particularly for poor and vulnerable groups (Geoppel et al. 2015). The chronically ill poor were less likely to have access to fundamental long-term care and more inclined to confront financial hardship than the well-off in all
nations in the examination, with the exception of South Africa, where essential health insurance is provided free to all South Africans.

The staggering expense of treating and overseeing chronic diseases can have a huge financial effect on individual and family spending plans. The illness of the primary or sole provider in a family can catastrophically affect the family's funds, drawing such family into poverty. At the family unit level, undesirable practices like smoking and heavy liquor consumption, can also be a drain on family income, as it is costly to keep up such habits.

The World Health Report (2010) states that every year, 100 million individuals are pushed into destitution since they need to pay up-front for health services. The report demonstrates that immediate out-of-pocket payments still represent over 50% of total health care expenditure in a large number of low-and middle-income nations. This means the greater part of health expenditure in these nations comes directly from the pocket of people. The discoveries of another investigation uncovered that one in four families living in the poorest nations borrow money or sell resources and assets to pay for medical services (Kruk et al, 2009). In Ghana, the expense of managing a chronic condition, for example, diabetes, is more than the average individual income (de-Graft Aikins 2007). Consequentially, this draws families into the low-income bracket and into exceedingly awful circumstances of poverty.

Indisputably, lifestyle choices and habits can also predispose people to chronic diseases, including, diabetes, hypertension, stroke, cancer, and arthritis (Steyn and Damasceno, 2006). Eating regimen, smoking and tobacco use, and physical movement are the most well-known individual-level factors that influence the health of the person through the years. The consequences of such chronic conditions are colossal, particularly among the elderly in Ghana, who endure a twofold burden. In addition to the ordinary challenges of aging, daily activities become increasingly burdensome and difficult to manage with chronic disease (Pappachan, 2011). In 2003, hypertension, diabetes, cancer and stroke were the top 10
reasons for mortality in Ghana (de-Graft Aikins, 2007). It is apparent from past investigations that the likelihood of developing most chronic disease increases quickly as age advances and leaves the elderly most helpless against the danger of chronic illness (Ayernor, 2012).

As indicated by the World Health Organization (2008), around 69% to 70% of deaths in the African continent alone in 2006 were caused by chronic diseases. Complicating this picture was the way that African nations, including Ghana, are not well prepared and have a lack of social health care assets to adapt to the expansion of chronic diseases. Undeveloped health care frameworks, poor administration, and deficient financing are among the variables that contributed to the increase in deaths identified with chronic conditions (Aikins et al., 2010).

2.6 Challenges Encountered by Elderly Persons Living with Chronic Disease

Chronic diseases are the primary driver of illness, fragility and death in Australia, representing 90% of all demise in 2011 (AIHW 2014). The presentation of interminable chronic diseases casts a shadow over the triumphs in the battle against infections and child deaths in the late nineteenth and mid-twentieth centuries. Through the advancement of ways of life and ageing of the people, chronic diseases have grown progressively common and are presently causing numerous health challenges. Various diseases and conditions can be categorized as chronic diseases. Chronically ill patients can see their personal quality of life significantly reduced (Gusmao, Mion and Pierin (2009). The inability of people with diabetes, for example, to live life according to their expected standard interferes with their self-worth and can lead to stress and depression. Likewise, the physiological changes brought about by hypertension influence general physical and mental health and quality of life. Hypertension is considered clinically imperative. It influences the quality of life of patients experiencing it (Kiadaliri, Najafi and Mirmalek-Sani, 2013).
Numerous diseases and conditions can be designated as chronic diseases. Chronically ill patients may encounter a huge disintegration in their quality of life as a result of their progressing condition (de Gusmao, Mion & Pierin, 2009). Due to the functional burden caused by chronic disease like chronic obstructive pulmonary disease (COPD), patients with this disease have higher rates of long-term private and home care for individuals with COPD contrasted with individuals with lung cancer. An investigation found that in the last years of life 41% of individuals determined to have COPD were practically compromised to the point of requiring long-term institutional care for a year (Goodridge et al., 2008).

As shown by the World Health Organization (WHO), chronic diseases, specifically coronary illness, cerebral vascular accidents, cancer, chronic respiratory ailments and diabetes, influence and abbreviate the lives of an excessive number of individuals around the globe. This happens not just in high-income nations or in developed nations. Today, four out of five deaths happen in low-middle or middle-income nations, and the inhabitants of these nations tend to contract these diseases young, experience the ill effects of long-term disease (often with preventable complications) (WHO, 2005).

WHO (2005) found that, of 58 million deaths globally in 2005, 35 million were due to chronic disease. Chronic diseases are now the main cause of mortality among the elderly in all nations, and the number suffering from these diseases is expected to increase by 17% in the next decade. This poses a major challenge to public health, social services, and national economies.

Elderly individuals confront the challenges related with functional inadequacy and chronic disease. Functional deterioration related to chronic disease is especially pronounced in elderly patients (Moe, Hellzen & Enmarker, 2013). In the overall elderly population, physical change and morbidity create challenges for maintaining personal accommodation and finances, often leading to premature death and placing strain on official institutions.
(Painter & Marcus, 2013). Individuals experiencing chronic disease may suffer from exhaustion, poor conduct, incapacity, and death. Chronic disease often comes with consequences for mental health, which may include loss of personal relationships, loss of autonomy, loss of creative energy, and loss of emotional feelings (Weingarten, 2012). A study by Wikman and his partners (2011) uncovered that diagnosis of chronic disease prompts upsetting encounters that influence the person's motivation. Another investigation of the National Institute of Health and Clinical Excellence (2011) revealed that individuals experiencing chronic hypertension tended to suffer more often than people without hypertension from brain stroke, chronic kidney failure, psychological decrease, and unexpected death. Studies led by Kagee (2010), and Kagee and Martin (2010) concluded that individuals experiencing chronic hypertension should adjust to diagnosis and follow-up treatment, including psychological examination.

According to Aikins’ (2003) study conducted in Accra, the significant medical issues of elderly persons living in health centres were hypertension, cerebral vascular diseases, diabetes and joint inflammation. Chronic diseases cause genuine disruptions of life and employment. In Ghana, the investigation demonstrated that "diabetes caused a disturbance of the body, social identity, family/social relationships, economic circumstance and livelihoods” (Aikins, 2003). An epidemic of cervical diseases was found at the Korle-Bu Teaching Hospital in the 1920s (Pobee, 2006). Pobee focused on that cerebrum and cardiovascular issues seemed to expand at Korle-Bu Teaching Hospital somewhere in the range of the 1960s. Nonetheless, the long history of chronic disease has raised the worries of specialists and experts as much as transmitted infections like HIV/AIDS (Aikins, 2007).

2.7 Coping Strategies Adopted by Elderly Persons Living with Chronic Diseases

Holland et al. (2016) investigated patient adaptation to chronic kidney failure and concluded that, despite the challenges posed by the condition, through rhythms, routines, and
struggles of day-to-day life, patients develop approaches for adapting to the illness and enhancing their wellbeing. The authors distinguish between two main emotional adjustment frameworks, specifically, support for religion/faith and search for family support (Holland et al., 2016). Also discussed is issue-based adaptation, which the authors describe as using flexibility as a method for rationalizing experience and seeking treatment and bodily care to limit the challenges associated with the condition. Responses to the infection and adjustment procedures are vital variables to consider when exploring ways to enhance the wellbeing and self-worth of patients (Holland et al., 2016). Further, analyses of adjustment strategies will permit healthcare groups to respond adequately to patients’ feelings of cynicism and demoralization in response to disease. In such manner, the findings demonstrate that patients with chronic disease may benefit from holistic treatment that gives attention to their general life experience, rather than targeting the disease alone (Holland et al., 2016).

Older persons learn to live with chronic diseases through mental coping strategies, such as "problem solving" and "emotional management" (Folkman et al., 2012). Practitioners can encourage effective adaption, which includes dealing with the emotions caused by chronic diseases, by allowing the individual to express his annoyance or dissatisfaction over the ailment (Cavanaugh and Blanchard-Fields, 2015). Over the long run, mental methodologies used to treat chronic diseases incorporate the individual’s emotions and motivations. These can be assessed by specialists through a progression of methods examining the extent of perceived control, autonomy, self-improvement and pleasant aspects of life (Weingarten, 2012). Elderly with chronic diseases frequently confront chronic disillusionment. As indicated by Weingarten (2012), the psychological consequences of living with chronic illness can be remedied through different activities, including social participation. For instance, an elderly person with chronic disease can be urged to have more
rewarding associations with his or her life partners, kids, companions, and with numerous health care specialists.

One of the primary goals of coping with chronic diseases is to attain a reasonable level of personal satisfaction. Personal satisfaction is a multidimensional concept incorporating the natural, mental and socio-cultural parts of the life cycle of a person with chronic diseases. Weakness is a staggering and horrifying experience that limits the physical and social capability of the elderly. Weariness is a key aspect of fragility disorder identified with the process of aging. The agony of chronic disease causes pain, loss of vitality, diminished personal satisfaction, and can prompt an enduring cycle of tension, torment and nervousness (Egerton, 2013). Physiotherapists have a central influence in recovery from numerous chronic diseases and can greatly improve physical activity in the elderly. These physiotherapists are situated in essential medical services offices in rural regions and hospitals (Egerton, 2013). Elderly persons also study how to live and concentrate their efforts on living with chronic diseases and learn to manage them through psychological methodologies like "adapting to issues" and "managing emotions" (Folkman, Lazurus, Schetter, Christine and Gruen, 2012). As per Cavanaugh et al., a critical thinking-based methodology has endeavoured to address elderly chronic disease patients’ issues associated with taking medication (Cavanaugh and Blanchard-Fields, 2005). Psychological approaches used to manage chronic diseases incorporate the emotional features of the well-being of an elderly person. These can be assessed by specialists through a progression of measures, including, for instance, perceived control scales, autonomy, self-accomplishment and fulfilment of quality of life (Weingarten, 2012).

2.8 Theoretical Framework

This study is underpinned by one helpful theory by Bury (1982) called biographical disruption theory, which has been exceptionally valuable in estimating the strength of a
populace. Bury presented the idea of "biographical disruption" in 1982. This theory posited that chronic disease is interference, a discontinuity in everyday life. Everyday life as the chronic disease sufferer experiences it is interrupted, maybe totally unavailable. The life of a person with a chronic disease is totally hindered and brimming with doubts; this makes the patient to be overpowered as far as possible by setting more significance on the body condition.

Bury (1982) presented the idea of “biographical disruption” after an investigation of patients with rheumatoid arthritis. His examination focused on the early stages of diagnosis and adjustment to chronic diseases. Based on this research, Bury proposed that chronic diseases change regular daily living in three different ways. In the first place, chronic diseases hamper day-to-day activities, upsetting activities and schedules that were previously taken-for-granted. This effect on regular day-to-day life includes uncertainty about conflicting and unpredictable side effects. Secondly, the break stretches out to the descriptive systems of the person suffering from chronic diseases, which prompts reflections on one’s identity and personality, and a rethinking of the self-concept. Bury clarifies this point by utilizing the case of young women found to have rheumatoid arthritis. This disease is widely regarded as an ailment of the elderly, such that the diagnosis of rheumatoid arthritis for young people between 20- and 30-years-old is disturbing in contrast to the perceived "normal course" (Bury, 1982). The third dimension of Bury’s biographical disruption theory pertains to people’s response to the aggravation and their ability to adjust to evolving situations. This includes how individuals discover and utilize assets (for instance, social networks, organizations) and how they are unprotected from the danger of social separation and dependence (Bury, 1982).

The theory shows, in first place, that one’s total concept of self and of the social world is vexed by the experience of the ailment. Besides, it proposes that the biographic setting
regularly used to comprehend regular daily existence is additionally discontinuous, which requires rethinking the biographical information. A third implication is the use of assets in the variable states of chronic diseases. The association of cognitive, material and practical assets to upgrade the biography and safeguard daily life is the versatile response to the unsettling influence. The present study is concerned with ageing and chronic diseases, both in terms of magnitude and significance. As Bury (1982) contends, the meaning given to the sickness determines how it is treated in everyday life.

2.8.1 Significance of the Theory to the Study

Bury’s theory (1982) is related to the present study since every one of the study participants interviewed in this research were diagnosed to have chronic diseases unexpectedly. There is a difference between chronic diseases in the study populace and the age range; in any case, Bury's theory clarifies that they impact numerous aspects of the patient's life. The theory of biographical disruption elucidated how elderly with chronic diseases react to unsettling influences and embrace changeable conditions. The theory has enabled the researcher to acknowledge how an elderly individual with a chronic disease reacts to turbulences and adjusts to changing conditions. The theory has helped to clarify how chronic diseases change the body, social identity, family and social relationships, and the economic states of the elderly living with chronic diseases in Akim Oda. A third contribution of the theory pertains to the mobilization of assets against the changed states of the chronic condition. For instance, the recruitment of cognitive, material and practical resources to repair the biography and keep up daily life is the observed adaptive response to the interruptions by the study participants. Moreover, the biographical disruption theory suggests how health experts guide elderly with chronic diseases. Pertinent to the present research on ageing and coping strategies of elderly chronic disease patients, Bury (1982) contends that the importance attributed to an ailment influences how it is relieved in regular day-to-day life.
Accordingly, this theory has guided the entire research planned and conducted in Akim Oda, in the eastern region of Ghana.
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

Willig (2008) argues from a pragmatic viewpoint that the aim of research is not about generating abstract truth free from the experience of people but rather to provide insight that will ultimately benefit human beings. Yin (2003) defines research methodology as research activities, the means by which to proceed, how to measure progress, and what comprises achievement. Moreover, research methodology is both an orderly method to tackle an issue and the science of studying how research is to be done (Rajaskar, 2006). Hence this chapter discusses the research methodology and processes employed in investigating ageing and chronic diseases among the elderly in Akim Oda in the Eastern region of Ghana. It indicates the fitting methods utilized with the end goal to examine the reasons and presumptions hidden in the decisions made. This chapter covers the study participants, the sampling technique, and the data collection procedures the researcher followed to reach the findings.

3.2 Research Approach and Design

The study employed a qualitative research design. Qualitative research designs are appropriate for descriptive, explanatory and exploratory purposes, are mostly used in studies that take the individual as the unit of analysis and are useful in assessing behaviours and orientations in a large population (Babbie, 2004). It is a naturalistic methodology that tries to comprehend phenomena in context, in an everyday world setting where the researcher does not attempt to control the factors under observation (Patton, 2002). This is upheld by Creswell (2014) who characterizes qualitative research as a method for investigating and understanding the implications people or groups attribute to a social or human issue. Qualitative research methodology is essential in investigating people’s qualities, convictions, attitudes, states of mind and practices. It produces knowledge and understanding through
discourse between the researcher and the respondent (Maguire, 1987). It is especially vital when managing sensitive topics, such as ageing and chronic diseases.

The purpose for using a qualitative design in this study was that the study aims to gather detailed descriptive data from elderly persons experiencing chronic diseases in Akim Oda. A qualitative approach enabled the researcher to gather in-depth data from the participants about ageing and chronic diseases, which has helped in understanding the importance people or groups attached to the social issues of ageing and chronic diseases.

There are several other considerations when choosing to adopt a qualitative research approach. Strauss and Corbin (1990) claimed that qualitative techniques can be utilized to more readily see any phenomenon about which little is yet known. They can likewise be utilized to increase new points of view on things about which much is as of now known, or to acquire more in-depth data that might be difficult to gather quantitatively. This qualitative research configuration is an exploratory methodology concerned with understanding social phenomena from the actor’s point of view through interpersonal investigation. Qualitative research, as indicated by Cohen et al. (2007), enables the researcher to utilize ethnographic description and immerses the researcher in the study. The approach was useful for the study as it enabled the researcher to probe deeply to bring out the types of chronic conditions, factors, challenges and coping strategies for elderly persons with chronic diseases in Akim Oda. There are different qualitative research designs, namely, ethnography, phenomenology, case study, grounded-theory, and narrative research (Creswell, 2014). This study employed phenomenological approach to research. Phenomenology involves an in-depth study of a phenomenon in an individual or small number of individuals, or a programme event or process within a specific context.
3.3 Study Area

The study was conducted in Akim Oda, the capital of Birim Central Municipal District in the Eastern Region. This area was ideal because it is cosmopolitan with a diverse elderly population and has the only government health facility in the municipal area. The health facility provides services for many elderly persons, and it serves as the only referral hospital to other health facilities within the municipality. According to Ghana Population and Housing Census in 2010, Akim Oda had a settlement population of 63,081 people, comprising 37.7% of the total population of Birim Central Municipality. The town lies in a hilly side of the country with rain backwoods vegetation in the Birim River bowl at a height of 196 meters above ocean level. The Birim Central Municipality is one of the 26 Administrative Districts in the Eastern Region. It was cut out of the previous Birim South District in 2007 under Legislative Instrument (L.I.) 1863. The region covers a territory of 790.496 square kilometres, making up about 6% of the aggregate zone of the Eastern Region with an aggregate populace of 167,306. The region borders Akyemansa and Denkyembour regions to the north, Birim South District to the West, Asikuma/Odoben/Brakwa and Agona East District to the South, and West Akim Municipality to the East. The metropolitan capital is Akim Oda. There are around 167 linkages and 4 Zonal Councils in the district. These are Oda, Asene/Aboabo, Manso and Akroso. Below is the map of Birim Central municipality indicating Akim Oda government hospital, where the research was conducted.
3.3.1 Population Size and Distribution

The 2010 Ghana population and housing census shows a municipal population of 144,869 with an annual growth rate of 2.4%. This figure constitutes 5.5% of the total regional population of 2,633,164. The male population accounts for 47.8%, and the female population constitutes 52.2% of the total population of the municipality. The municipal population is currently estimated at 167,306. The municipality is predominantly urban, with 67.7% dwelling in cities and 32.3% in rural areas.
Table 1. Population Distribution by Zonal Council

<table>
<thead>
<tr>
<th>Zonal Council</th>
<th>Total Population</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akim Oda</td>
<td>63,081</td>
<td>37.7</td>
</tr>
<tr>
<td>Akroso</td>
<td>44,876</td>
<td>26.8</td>
</tr>
<tr>
<td>Manso</td>
<td>43,703</td>
<td>26.1</td>
</tr>
<tr>
<td>Asene/Aboabo</td>
<td>15,646</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>167,306</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Source: Projected from 2010 Population & Housing Census.*

3.3.2 Population Pyramid

The population pyramid for the district demonstrates a wide base, which continuously diminishes with expanding age and tapers to a point. Despite the fact that the age structure demonstrates, for the most part, an energetic populace, the pyramid demonstrates that the populace aged 5-9 years is generally smaller than that of 10-14 years. This suggests that there may have been age distorting or generally high mortality among the 5- to 9-year age group.

From table 1.6, there is a greater number of males than females in all age brackets from 0-4 to 10-14 years, yet the populace tends to be female-predominant in all age brackets from 15-19 years to 85 years and older. This could be due to migration, with more men leaving the area to find work, more women entering for business exercises, and/or greater mortality among men.
Table 2. Age Structure by Sex in the Birim Central Municipality

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Both Sexes</th>
<th>Male</th>
<th>Female</th>
<th>% Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>144,869</td>
<td>69,304</td>
<td>75,565</td>
<td>100</td>
</tr>
<tr>
<td>0-4</td>
<td>19,577</td>
<td>9,834</td>
<td>9,743</td>
<td>13.5</td>
</tr>
<tr>
<td>5-9</td>
<td>17,971</td>
<td>9,235</td>
<td>8,736</td>
<td>12.4</td>
</tr>
<tr>
<td>10-14</td>
<td>18,967</td>
<td>9,516</td>
<td>9,651</td>
<td>13.1</td>
</tr>
<tr>
<td>15-19</td>
<td>16,316</td>
<td>8,020</td>
<td>8,296</td>
<td>11.3</td>
</tr>
<tr>
<td>20-24</td>
<td>12,635</td>
<td>5,670</td>
<td>6,965</td>
<td>8.7</td>
</tr>
<tr>
<td>25-29</td>
<td>10,405</td>
<td>4,655</td>
<td>5,750</td>
<td>7.2</td>
</tr>
<tr>
<td>30-34</td>
<td>8,803</td>
<td>3,987</td>
<td>4,816</td>
<td>6.1</td>
</tr>
<tr>
<td>35-39</td>
<td>8,278</td>
<td>3,743</td>
<td>4,535</td>
<td>5.7</td>
</tr>
<tr>
<td>40-44</td>
<td>7,252</td>
<td>3,438</td>
<td>3,814</td>
<td>5.0</td>
</tr>
<tr>
<td>45-49</td>
<td>5,937</td>
<td>2,827</td>
<td>3,110</td>
<td>4.1</td>
</tr>
<tr>
<td>50-54</td>
<td>5,344</td>
<td>2,494</td>
<td>2,850</td>
<td>3.7</td>
</tr>
<tr>
<td>55-59</td>
<td>3,485</td>
<td>1,643</td>
<td>1,842</td>
<td>2.4</td>
</tr>
<tr>
<td>60-64</td>
<td>2,998</td>
<td>1,373</td>
<td>1,625</td>
<td>2.1</td>
</tr>
<tr>
<td>65-69</td>
<td>1,849</td>
<td>866</td>
<td>983</td>
<td>1.3</td>
</tr>
<tr>
<td>70-74</td>
<td>2,158</td>
<td>871</td>
<td>1,287</td>
<td>1.5</td>
</tr>
<tr>
<td>75-79</td>
<td>1,194</td>
<td>529</td>
<td>665</td>
<td>0.8</td>
</tr>
<tr>
<td>80+</td>
<td>1,700</td>
<td>603</td>
<td>1,097</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>144,869</td>
<td>69,304</td>
<td>75,565</td>
<td>100</td>
</tr>
</tbody>
</table>

3.4 Target Population

The target population for this study was elderly people living with chronic disease in Akim Oda. This population was comprised of both men and women between the ages of 60 years and above, and health personnel at Akim Oda Government Hospital.

3.5 Sampling

As per Bobbie (2007), sampling includes taking a delegate selection of the populace and utilizing the information gathered as research data; or the capacity of the researcher to choose a segment of the population that is representative of trends in the populace at-large.

Purposive sampling was used to recruit participants for the study. Purposive sampling involves a situation whereby the researcher deliberately selects participants for a study due to their qualities or focuses on particular characteristics which best empower the researcher to answer the research questions (Russell, 2002). A purposive sampling technique was employed, because it enabled the researcher to obtain thorough data from participants who were knowledgeable and experienced in issues related to ageing and chronic diseases (Patton, 2002). Also, purposive sampling allowed the researcher to decisively select participants due to the qualities they have and according to the criteria determined by the purpose of the research (Denzin & Lincoln, 2011). The researcher selected elderly persons living with chronic diseases specifically because they have experienced chronic diseases.

Health personnel of the Akim Oda Government Hospital were also selected as gatekeepers to the elderly persons living with chronic diseases. Elderly persons living with chronic diseases were purposively sampled based on their age and their health status. Four health professionals, specifically two doctors and two nurses, were selected from the health facility. Health professionals who provide treatment or any other services to elderly persons living with chronic diseases at the health facility were selected for the study. Demographic information of elderly persons living with chronic diseases were obtained. The researcher
contacted the research participants directly, through phone calls and emails, and provided them with details of the purpose and objectives of the study before they agreed to be part of the study. Interviews were planned after the research participants agreed to take part in the study, and all meetings were conducted on clinic days. Interviews were conducted in both Twi and English. Three interviews were conducted in Twi and twenty were in English. Participants were asked to choose which language they wanted to be interviewed in.

3.6 Inclusion Criteria for Participants

Elderly persons 60 years and above, experiencing chronic disease for at least one year, accessing health care in Akim Oda Government Hospital, and living in Akim Oda for at least one year were selected as study participants. Health personnel who have worked at the Akim Oda Government Hospital with the elderly persons living with chronic diseases for more than a year were also included in the study.

3.7 Study Population

The study population were comprised of both male and female elderly persons from age 60 years and above living with chronic diseases, who receive services from Akim Oda Government Hospital, in addition to health personnel at Akim Oda Government Hospital.

3.8 Sample Size

A total of 23 participants were chosen for the study since this was the point at which the researcher could reach data saturation. Denzin and Lincoln (2011) argue that the number of participants for qualitative study should be between 5 and 25 in order to ensure that adequate data is obtained, and to reduce the tendency of data saturation. This is supported by Creswell (1998) who argues that five to 25 people for qualitative research is enough to arrive at data saturation. 19 of the participants (10 male and 9 female) were elderly persons living with chronic diseases, and the remaining four were health personnel at Akim Oda Government Hospital.
3.9 Source of Data

Primary data was obtained from participants through in-depth interviews with the aid of an interview guide, which was designed in English. The researcher sought permission from participants and audio recorded the interviews. Interviews were held at a time and place suitable to the study participants, and each interview lasted between 30 minutes and one hour. The audio recorded data was kept on the researcher’s personal computer and protected with a password to prevent unauthorized access. Interviews were conducted in English and Twi, because the researcher is fluent in both of these languages. In-depth interviews are appropriate for conducting a comprehensive investigation and when soliciting information on personal experiences with delicate subject matter (Ritchie & Lewis, 2003). An interview guide was constructed to collect data relevant to the aims and objectives of the study. The purpose of the interview guide was to ensure that the researcher maintained focus throughout the interview and solicited information of relevance to the research questions and objectives, without becoming diverted by conversation.

3.10 Methods of Data Collection

An informational meeting was held at Akim Oda Government Hospital with persons living with chronic diseases. The study utilized primary data. Interviewing was the principle instrument for acquiring information. The interview guide was written in English, but interviews were conducted in English and Twi. An interview was scheduled with participants and primary data were collected through in-depth interviews with persons living with chronic diseases. The researcher obtained consent through the use of a consent form that participants signed at the start of each interview. An audio recorder was used with permission to record interviews and complemented with note-taking. Each interview lasted between 30 minutes to an hour and was conducted at a time and place advantageous to the study participants. The
researcher wrote down whatever he observed in the environment of the study for purposes of reflexivity and trustworthiness of the study.

3.11 Data Management

All twenty-three qualitative interviews conducted were captured on a digital voice recorder. Each audio file that was transcribed was assigned a respondent identification number. In-depth Interviews (IDIs) and Key Informant Interviews (KIIs) were separately identified. All IDIs and KIIs were assigned identification numbers within the range of the number of interviews conducted. Identifications ranged from IDI1 to IDI19 and KII1 to KII4 for in-depth interviews with the aged and health professionals, respectively.

3.12 Data Analysis

Data was analysed with the aid of NVivo 11, which is a software used to analyse qualitative data with the following node structure that suits the thematic analysis. Thematic analysis (Attride-Stirling, 2001) was used to analyse and present findings into basic themes, organizing themes and global themes. The process of thematic analysis—profiling, coding, thematic framework and thematic network of results—is presented under each research question. The processes involved in thematic analysis is detailed in the following subsections for procedural clarity.

All qualitative interviews were recorded and checked for voice file clarity. Recorded audio data was transcribed verbatim into English. Transcripts were uploaded into NVivo 11, where data was thematically analysed into three levels of themes. Uploaded transcripts were coded both inductively and deductively into basic themes.

3.13 Coding

Transcripts were uploaded into NVivo 11 where data was thematically analysed (Attride-Stirling, 2001) into three levels of themes. Uploaded transcripts were coded inductively and deductively. A coding scheme guided by the research questions was used to
code transcripts into basic themes (level 1 nodes/grandchild nodes in NVivo). Relevant indicators were grouped in two or more basic themes (level 1 nodes), which were then organized through text search and frequency queries to identify relevant patterns. These were further coded into organizing themes (level 2 nodes/child nodes). All organizing themes were summarized into global themes that encapsulated all emerging themes under each research question. Global themes (level 3 nodes) summarized all emerging inductive and deductive themes. NVivo concept maps were used to construct thematic networks that present a visual summary of how themes spread out and connect to reveal results under each objective and research question. Each research question was considered as a global theme with sub-organizing and basic themes. Results from the coding are presented in a coding frequency table and a thematic framework in table 6. The coding frequency table shows all three levels of themes in the first column; respondent identification numbers head the subsequent columns. Codes are plotted where respondent IDs and basic theme rows intersect in the table. The thematic framework table shows the global theme that summarizes data addressing the research questions, organizing themes, basic themes, the operational description of the basic theme, the frequency of basic themes, and a sample quote that was coded into the basic theme. Sample quotes were directly exported from NVivo and they indicate the source transcript. Samples of both tables are presented to show how they were constructed; due to their size, complete tables are appended for further reference. The coding frequency table presented for illustration presented coding for 16 of the 19 respondents; however, the appended coding frequency table has coding for all 19 respondents across all four global themes that represent the research questions.

3.14 Ethical Considerations

This section contains the researcher’s ethical considerations in the conduct of this study, especially with respect to data collection. The substance of ethical consideration in
social research is to guarantee uprightness in the research procedures, to think about conceivable harm or advantages to research participants and ensure the soundness of the discoveries and conclusions. Because social science inquiry includes individuals with sentiments and feelings, it is vital to give due consideration to ethics in research design and confront potential ethical dilemmas that may present themselves in the course of research. With sensitivity to the above, the researcher observed the following ethical considerations.

3.15 Informed Consent

This refers to the right of individuals to make a free and informed decision about whether or not to take part in the research. The researcher offered an introductory letter and read out the informed consent statement to participants before seeking their consent to begin the interview. This guaranteed that individuals wilfully take part in the research with full acknowledgement of potential harm and advantages.

3.16 Confidentiality and Anonymity

Anonymity and confidentiality was another important consideration. Participants were assured that whatever they say would be kept confidential and their anonymity protected. By so doing their identity or their positions would not be abused or uncovered. Participants’ names are not used in any part of the study; instead pseudonyms were assigned.

3.17 Plagiarism

In order to avoid wrongful appropriation, stealing and publication of another author’s work, plagiarism was avoided by the researcher by acknowledging authors used in the study.

3.18 Member-Checking

Member-checking was used to ensure the fidelity of the study by reading out part of the transcribed data to participants for confirmation.
3.19 Limitation of the Study

In the course of transcribing the data from Twi to the English language, some words were challenging to translate into English; however, related interpretations were provided to substitute these Twi words.
CHAPTER FOUR
PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter describes post-data collection management and analysis procedures used to generate results in this study. It also provides an overview of participant profiles, including gender, educational background, and other factors expected to shape life experiences. Further, this chapter presents the study results in context of the theoretical framework. The presentation of findings derived from the data is presented such that the presentation and discussion are integrated.

4.2 Demographic information of participants

As a background to the results, the study profiles respondents by variables considered key to shaping their perspectives and lived experiences. The elderly were profiled by their gender, age, marital status, religious affiliation, and occupation, sources of subsistence, educational background, health condition, number of years of treatment, and number of dependents. Key informants were profiled by gender, age, number of years working at the institution, educational background and status in the institution. General profiles summarize the number of respondents under each profile variable. Table 3 shows the general profile of In-depth Interview (IDIs) and Key Informants (KII).
Table 3. General profile of In-depth Interview respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>13</td>
</tr>
<tr>
<td>70-79</td>
<td>5</td>
</tr>
<tr>
<td>&gt;79</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1</td>
</tr>
<tr>
<td>Middle school</td>
<td>9</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Source of subsistence</td>
<td></td>
</tr>
<tr>
<td>Retired (Socially supported)</td>
<td>8</td>
</tr>
<tr>
<td>Self-employed and Socially supported</td>
<td>1</td>
</tr>
<tr>
<td>Farming</td>
<td>10</td>
</tr>
<tr>
<td>Number of years treating chronic condition</td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>10</td>
</tr>
<tr>
<td>6-10 years</td>
<td>7</td>
</tr>
<tr>
<td>11-15 years</td>
<td>1</td>
</tr>
<tr>
<td>20-25</td>
<td>1</td>
</tr>
<tr>
<td>Number of chronic condition(s)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Demographic Description of the aged participants

4.2.1 Gender and Age

The study targeted equal numbers of men and women in anticipation that gender is a potential variable that could affect the way the elderly experience chronic illnesses. Fewer women were reached, because targeted female respondents were not willing to be recorded. More than half of the respondents were in the age brackets of 60 to 69 years. Few respondents were between 70 to 79 years old, and only one respondent was above 79. The
experiences of the men differ from that of the women in terms of chronic disease severity and management.

4.2.2 Educational Background

Evidence from previous studies shows that educational levels of chronic disease patients have the tendency to influence their treatment and management patterns. In this study, most respondents attained middle-school education compared to fewer respondents who attained tertiary education. One respondent had primary education, while few respondents had no formal education at all.

4.2.3 Source of Subsistence

Chronic illness places financial burdens on patients. This study sought to identify the source(s) of income that sustained aged patients with chronic illness as an important welfare indicator. More than half of the study’s participants were sustained by farming as an economic activity. Apart from farming, many of the study participants were sustained by financial remittances from their social acquaintances. One respondent indicated that in addition to social remittances, he was self-employed by managing a pharmacy shop.

4.2.4 Number of Years of Treatment

The number of years of treatment among the respondents ranged from one year to 25 years. Most respondents had been managing their chronic illnesses between one and ten years. More specifically, most of the study’s respondents were in their first five years of their management, and fewer respondents were between six and ten years.

4.2.5 Number of Chronic Diseases

The experience of a single chronic disease differs from comorbidity, or the compresence of two chronic diseases. For this reason, the study also took note of the number of chronic illnesses that respondents suffered. Most of the respondents had one chronic illness. Patients with two chronic diseases were the second highest frequency. Few of the
respondents had three chronic diseases. Table 4 below shows a detailed profile of respondents. The characteristics of each respondent are detailed on a row under each column in the table.
<table>
<thead>
<tr>
<th>Respondent</th>
<th>Sex</th>
<th>Age</th>
<th>Marital Status</th>
<th>Religious Affiliation</th>
<th>Occupation</th>
<th>Source of subsistence</th>
<th>Educational Background</th>
<th>Health Condition(s)</th>
<th>Years of Treatment</th>
<th>Number of Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>78</td>
<td>Married</td>
<td>Christian</td>
<td>Farmer</td>
<td>Family &amp; Friends</td>
<td>Standard 1</td>
<td>Hypertension</td>
<td>5 years</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>73</td>
<td>Married</td>
<td>Muslim</td>
<td>Trading</td>
<td>Family &amp; Friends</td>
<td>None</td>
<td>Hypertension</td>
<td>21 years</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>60</td>
<td>Married</td>
<td>Christian</td>
<td>Trading</td>
<td>Family Remittances</td>
<td>Standard 4</td>
<td>Hypertension</td>
<td>6 years</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>61</td>
<td>Widow</td>
<td>Traditionalist</td>
<td>Farmer</td>
<td>Profit from sales of farm goods, Family Remittances</td>
<td>Form 4</td>
<td>Hypertension</td>
<td>2 years</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>67</td>
<td>Married</td>
<td>Christian</td>
<td>Farmer</td>
<td>Family Remittances</td>
<td>Form 4</td>
<td>Hypertension</td>
<td>1 year</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>67</td>
<td>Widow</td>
<td>Christian</td>
<td>Trader</td>
<td>Family &amp; Friends</td>
<td>None</td>
<td>Hypertension, Diabetes</td>
<td>5 years</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>61</td>
<td>Divorced</td>
<td>Christian</td>
<td>Trader</td>
<td>Profit, Family &amp; Friends Remittances</td>
<td>None</td>
<td>Hypertension, Diabetes</td>
<td>6 years</td>
<td>1</td>
</tr>
<tr>
<td>Respondent</td>
<td>Sex</td>
<td>Age</td>
<td>Marital Status</td>
<td>Religious Affiliation</td>
<td>Occupation</td>
<td>Source of subsistence</td>
<td>Educational Background</td>
<td>Health Condition(s)</td>
<td>Number of years of Treatment</td>
<td>Number of Dependents</td>
</tr>
<tr>
<td>------------</td>
<td>-----</td>
<td>-----</td>
<td>----------------</td>
<td>----------------------</td>
<td>------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>83</td>
<td>Married</td>
<td>Christian</td>
<td>Farmer</td>
<td>Family Remittances</td>
<td>Form 4</td>
<td>Hypertension, Diabetes</td>
<td>2 years</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>64</td>
<td>Widower</td>
<td>Christian</td>
<td>Artisan</td>
<td>Family Remittances</td>
<td>Form 4</td>
<td>Hypertension, Diabetes</td>
<td>15 years</td>
<td>None</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>75</td>
<td>Married</td>
<td>Christian</td>
<td>Retired</td>
<td>SSNIT payment, Family Remittance</td>
<td>Tertiary</td>
<td>Hypertension, Diabetes</td>
<td>7 years</td>
<td>None</td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>61</td>
<td>Married</td>
<td>Christian</td>
<td>Farmer</td>
<td>Family &amp; Friends</td>
<td>None</td>
<td>HIV</td>
<td>2 years</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>62</td>
<td>Divorced</td>
<td>Christian</td>
<td>Farmer</td>
<td>Profit, Family &amp; Friends</td>
<td>Form 4</td>
<td>HIV</td>
<td>6 years</td>
<td>6</td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>61</td>
<td>Divorced</td>
<td>Christian</td>
<td>Retired</td>
<td>SSNIT Payment, Family &amp; Friends</td>
<td>Form 4</td>
<td>HIV, Hypertension</td>
<td>2 years</td>
<td>4</td>
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<td>No</td>
<td>Gender</td>
<td>Age</td>
<td>Marital Status</td>
<td>Religion</td>
<td>Occupation</td>
<td>Education</td>
<td>Disability</td>
<td>Occupation Status</td>
<td>Years Employed</td>
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<tr>
<td>14</td>
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<td>Divorced</td>
<td>Christian</td>
<td>Trader</td>
<td>Family &amp; Friends</td>
<td>Tertiary</td>
<td>Remittances</td>
<td>6 years</td>
<td>2</td>
</tr>
<tr>
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<td>77</td>
<td>Married</td>
<td>Christian</td>
<td>None</td>
<td>Friends &amp; Family</td>
<td>Form 5</td>
<td>Remittances</td>
<td>5 years</td>
<td>1</td>
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<td>Divorced</td>
<td>Christian</td>
<td>Retired</td>
<td>Family Remittances</td>
<td>Tertiary</td>
<td>Hypertension, Stroke</td>
<td>6 years</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>70</td>
<td>Divorced</td>
<td>Christian</td>
<td>Retired</td>
<td>SSNIT payment, Family Remittances</td>
<td>Form 4</td>
<td>Hypertension</td>
<td>1 year</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>63</td>
<td>Married</td>
<td>Christian</td>
<td>Retired</td>
<td>SSNIT payment, Family Remittances</td>
<td>Tertiary</td>
<td>Stroke, Diabetes, Hypertension</td>
<td>3 years</td>
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</tr>
<tr>
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<td>Christian</td>
<td>Retired</td>
<td>SSNIT payment, Family Remittance</td>
<td>Tertiary</td>
<td>Hypertension</td>
<td>1 year</td>
<td>None</td>
</tr>
</tbody>
</table>
4.2.6 Profile of Institutional Respondents

The study purposively sampled hospital staff, with two medical doctors and two nurses as informants. Three of the respondents were males and one was a female. Three of the respondents were within the age brackets of 30 to 37; one of the respondents was 51 years old. All key informants had tertiary education. Two medical doctors and two nurses were interviewed.

Table 5. General profile of key informants

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>30-40</td>
<td>3</td>
</tr>
<tr>
<td>50-60</td>
<td>1</td>
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<tr>
<td>Education</td>
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<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Status in the Medical Institution</td>
<td></td>
</tr>
<tr>
<td>Medical Officers</td>
<td>2</td>
</tr>
<tr>
<td>Nurses</td>
<td>2</td>
</tr>
<tr>
<td>Years served at the medical institution</td>
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</tr>
<tr>
<td>1-5 years</td>
<td>3</td>
</tr>
<tr>
<td>30 years</td>
<td>1</td>
</tr>
<tr>
<td>Themes</td>
<td>R1</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----</td>
</tr>
<tr>
<td><strong>Type of chronic illness</strong></td>
<td></td>
</tr>
<tr>
<td>Communicable diseases</td>
<td></td>
</tr>
<tr>
<td><em>HIV</em></td>
<td></td>
</tr>
<tr>
<td><strong>Non-communicable</strong></td>
<td></td>
</tr>
<tr>
<td><em>Diabetes</em></td>
<td></td>
</tr>
<tr>
<td><em>Hypertension</em></td>
<td></td>
</tr>
<tr>
<td><em>Stroke</em></td>
<td></td>
</tr>
<tr>
<td><strong>Comorbidities</strong></td>
<td></td>
</tr>
<tr>
<td><em>Diabetes</em> and</td>
<td></td>
</tr>
<tr>
<td><em>Hypertension</em></td>
<td></td>
</tr>
<tr>
<td><em>Diabetes and Stroke</em></td>
<td></td>
</tr>
<tr>
<td><em>Diabetes, Hypertension, and Stroke</em></td>
<td></td>
</tr>
<tr>
<td><em>HIV and Stroke</em></td>
<td></td>
</tr>
</tbody>
</table>
Interpretation: Each research question is presented as a global theme, with subsequent organizing and basic themes under in the first column. Respondent IDs (as indicated in Table 6) are column headers from column two to the last column where the total numbers of row responses are indicated. (*) is indexed in the column where respondent ID intersects with basic themes. This shows the spread of basic themes and their contribution from respondents (R). The table shows codes associated with respondent one (RI) to respondent 19 (R19) excluding key informants.

4.3 Knowledge of Chronic Disease

Participants of the study were asked to explain 'chronic disease' and to produce examples of chronic diseases. Chronic disease was characterized as 'a hopeless condition' or 'a condition that doctors and herbalists can't cure but manage.' Two of the participants utilized the Twi articulation of chronic diseases: ‘koankɔ’ truly signifying 'hard to battle.' An unmistakable implication of the Twi term is that chronic diseases must be overseen but cannot be entirely overcome.

4.3.1 Types of chronic diseases affecting the elderly among the study population

The thematic network below shows the types of chronic diseases affecting the elderly in Akim Oda. The numbers attached to each of the chronic diseases in the thematic network below represents the number of participants who mentioned or are experiencing a particular chronic disease.
The study identified four major chronic diseases affecting the elderly in Akim Oda by the study participants (patient) and medical experts. The four major chronic diseases identified are diabetes, hypertension, HIV/AIDS, and stroke. Diseases identified were grouped into communicable and non-communicable diseases and comorbidities, as some of the study participants are experiencing more than one chronic condition. Types of communicable and non-communicable diseases and comorbidities identified are presented below.

4.3.2 Communicable Diseases

One type of communicable disease patients suffer from is HIV/AIDS. HIV/AIDS is the only communicable disease present among the study sample. Three of the participants indicated that they were suffering from HIV/AIDS. This can be seen in the responses beneath by two of the participants:

*I was diagnosed with HIV/AIDS two years ago. I have been on admission several times in different hospitals, until I came here for the doctor to discover that I have...*
HIV/AIDS. It was my stomach that was always disturbing me until I reported here (Male HIV/AIDS patient).

For almost six years I have been visiting this hospital, but in my third year, I was diagnosed to have acquired HIV (Female HIV/AIDS Patient).

4.3.3 Non-Communicable Diseases

The type of non-communicable diseases that study participants suffer from includes diabetes, hypertension and stroke.

4.3.4 Diabetes

Diabetes was reported as one of the non-communicable chronic diseases affecting the participants of the study. Diabetes is a chronic disease occurring as the result of high blood glucose (sugar) levels, either because of the inability of the pancreas to create enough insulin to process the glucose, or the body's failure to use the insulin delivered, or both. Five of the study participants mentioned that they were experiencing diabetes. There are three principle kinds of diabetes: Type 1 diabetes (otherwise called insulin-subordinate diabetes), type 2 diabetes (otherwise called diabetes mellitus—the commonest form of diabetes), and gestational diabetes (occurring during pregnancy). Type 1 diabetes happens at the infant stage when the immune system attacks insulin-delivering cells in the pancreas, doing perpetual harm to the cells (Charvatova, n.d.). This is what two study participants said:

About 5 years ago, I came to the hospital for a check-up and after the lab test, was told I had diabetes (Female Diabetic patient).

I don’t know how I contracted diabetes or when I contracted it, but I was diagnosed with the disease about six years ago (Male Diabetic Patient).

4.3.5 Hypertension

High blood pressure, otherwise called hypertension, is the force of blood against the artery walls as it courses through the body. Basically, hypertension is a response to build-up of fats in the arteries, where extra pressure is needed to allow blood to circulate. The danger
of developing hypertension increases with a number of behavioural and life course factors, including age, high sodium (salt) intake, low potassium intake (from fruits and vegetables), sedentary lifestyle, hereditary factors, stress, alcoholism, and smoking (WHO, 2011). The majority of the participants confirmed that they have been diagnosed to be hypertensive. The excerpts below indicate two patients’ experiences with their diagnosis:

For the past five years, I used to have severe headache and my heart was beating faster than before, so I told my son and he took me to hospital and the doctor told me I had hypertension (Male Hypertension Patient).

Two years ago, I was admitted and was told that I have hypertension, at this hospital. My blood pressure was high, and the doctor said it was not normal (Male Hypertension Patient).

4.3.6 Stroke

Stroke is a condition that occurs when the blood stream to a specific region of the cerebrum is obstructed, bringing about the death of brain tissue. Ischemic stroke is normally caused by a blood clot in an artery that provides blood to the brain. Stroke accounts for 5.5 million deaths worldwide every year, with 44 million permanently disabled (Debraj & Patil, 2011). Stroke was reported as one of the chronic diseases among the study participants. Below are statements from two stroke patients:

I experienced the first stroke in 1999. I used some medicine to control it until I became well for some time. The second stroke occurred in 2011 and this has been with me up to date (Female Stroke Patient).

I have had high blood pressure since 1991. One afternoon in September 2014, I was lying down, then I saw that I could not move my limbs, and my mouth had turned to the left side. At the same time my left shoulder could not turn (Female Stroke Patient).

The key informants indicated that stroke is among the most commonly reported chronic diseases at the hospital, along with diabetes, hypertension, and HIV/AIDS. As one doctor explained:

The most prevalent chronic diseases reported regularly in this institution are diabetes, hypertension, stroke, HIV and AIDS (Male Doctor).
4.3.7 Comorbidities

The study findings uncovered that the vast majority of the participants (16 out of 19) had at least two or more chronic illnesses: either communicable chronic disease with non-communicable chronic diseases or two non-communicable diseases. Among the six comorbid diseases, five participants had comorbidities of diabetes and hypertension. Other comorbidities identified in the study include diabetes and stroke, HIV/AIDS and hypertension, HIV/AIDS and stroke, and hypertension and stroke.

4.3.8 Diabetes and Hypertension

Some study participants confirmed that they are suffering from hypertension and diabetes. A few participants reported being first diagnosed with diabetes and later, hypertension. They believed that the diabetic drugs led to their hypertension. The escalating severity of diabetes can lead to hypertension, a comorbidity identified among the aged respondents of the study sample. On the other hand, several participants first reported to the hospital for symptoms of hypertension and were later diagnosed with diabetes. Below are statements of some of the participants:

Initially I was hypertensive, but the last check-up I had also revealed that I had diabetes. I don’t really understand what diabetes is. All I know is that I need to take my medication and take good care of myself, especially in terms of what I eat, so I can live longer (Female Diabetes and Hypertension Patient).

I went for a church camp meeting, and a nurse came around to check everybody’s blood pressure. The results showed that my blood pressure was very high, so I was advised to visit the hospital the following Monday for a proper check-up. I heeded the advice and further checks revealed that I had diabetes, but I do not know how I contracted the disease. All I can say is that my blood pressure was very high (Male Diabetes and Hypertension Patient).

4.3.9 Diabetes and Stroke

Two of the female participants also indicated that they were suffering from both diabetes and stroke. The presence of medically diagnosed diabetes and stroke was identified
as comorbidity in an aged person among the study sample. This can be seen in the statements below:

I am suffering from stroke. I am bedridden and cannot move at all. This is the third time I am suffering from stroke and it is more severe. I am also suffering from diabetes (Female Stroke and Diabetes Patient).

I was sick and was rushed to the hospital and the doctor detected that I had stroke, and later, they got to know that I had diabetes in addition (Female Stroke and Diabetes Patient).

4.3.10 Hypertension and Stroke

Two males and a female also confirmed that they were suffering from both hypertension and stroke. All the three study participants indicated that they had hypertension before the stroke. The findings below describe the presence of medically diagnosed hypertension and stroke in two aged respondents from the study’s sample.

The same high blood pressure brought me to the hospital. First, they could not detect but later I had stroke and I went to the physiotherapy department (Female Hypertensive and Stroke Patient).

I knew I had only stroke, although the doctor said I am hypertensive too. I am very much disturbed with my hypertension than the stroke (Male Hypertension and Stroke Patient).

4.3.11 Hypertension and HIV/AIDS

One of the study participants who was taking medication for HIV/AIDS shared that he also struggled with hypertension and was trying to treat both. The findings underneath explain it.

I am hypertensive in addition to my HIV/AIDS, but I came here purposely for my HIV/AIDS medication (Female Hypertension and HIV).
4.3.12 Hypertension, Diabetes, and Stroke

Some study participants revealed that they have been diagnosed with all three non-communicable chronic diseases identified in the study. In the interview excerpts below, two patients describe their experience with this comorbidity.

*I had diabetes and hypertension, so I think that led to the stroke* (Male Diabetic Patient).

*I am suffering from diabetes. I am bedridden and can’t move at all. This is the third time of experiencing stroke which is very severe. I am also suffering from stroke. As for the hypertension, I don’t think about it because they give us free medication* (Female. Stroke Patient).

4.3.13 Discussion of Types of Chronic Diseases

Participants in the study indicated that they were suffering from communicable (HIV/AIDS) and, non-communicable diseases (diabetes, stroke and hypertension), with most of the participants having comorbid conditions. The results revealed that most of the participants had two or more diseases. Among the six comorbidities, five participants had comorbid diseases of diabetes and hypertension. Other comorbid diseases identified in the study include diabetes and stroke, HIV and hypertension, HIV and stroke, and hypertension and stroke. The 2007–8 National Health Survey of Australia reports that 35% of the populace (7 million individuals) reported having at least 1 or 2 of the accompanying chronic conditions: diabetes, cerebrovascular illness (generally stroke), stroke, depression, or hypertension, and the prevalence of disease expanded with age (AIHW 2012). This is in accordance with what was found in Akim Oda. What’s more, the World Health Organization (2008) demonstrates that diabetes mellitus and hypertension are significant general medical issues that are evaluated to cause a million unexpected losses internationally each year. This is corroborated by the experiences of study participants, since most of them are suffering from these diseases and are facing several challenges as a result.

This is also in agreement with a qualitative study conducted by Deenadayalan (2011)
on “Health Care Seeking Behaviour of Elderly in Tamil Nadu (South India),” where findings show that the majority reported a single ailment. Major ailments in urban regions were diabetes mellitus, hypertension, and stroke, whereas the rural regions reported joint and bone disorders, diabetes mellitus and hypertension. Diabetes was identified as one of the major and prevalent ailments. This finding also corroborates a study piloted by Shaw and colleagues (2010), which shows that the global prevalence of diabetes among adults will increase in developing countries by 2030. The study revealed how these chronic diseases are diagnosed with symptom experience. Symptom experience explores the feelings, understandings and interpretations of patients with chronic diseases. Patients’ symptom knowledge was assessed by medical experts. The symptoms of these chronic diseases aid in diagnosing the health conditions of the aged. It was revealed that one of the symptoms of diabetes is that patients are not satisfied when they eat more food and drink. Another symptom of diabetes is recurrent urination. Stroke was diagnosed with impairment in the central nervous system of the patient. This shows that the symptom experience of the aged differs depending on the type of chronic disease. The study revealed varied symptom experiences among patients living with chronic diseases. In the face of these conditions, elderly patients develop adaptive strategies to improve their conditions of life and well-being.

Some patients revealed that they have no problem with hypertension, because they receive free medication. They do, however, worry about their other ailments, because they do not have the means to pursue proper treatment. Aikins (2007) found that poor communities are more likely than their rich counterparts to endure difficulties of, and die prematurely from, chronic diseases because of absence of access to quality medical services. The case of Akim Oda, however, reveals a disparity in disease treatment within a single community. Like the poor of Aikins’ study, patients in Akim Oda showed a high prevalence of comorbidities, but their accounts also reveal a structural disparity between the treatments of different
diseases. Thus, as a female stroke patient quoted above explained, although she suffers from hypertension, stroke, and diabetes, it is only the latter two that cause her worry. This suggests both the success of offering free hypertension medication and the need for more such programs to cover treatment for other chronic diseases.

Results from the study reflected a positive association between age and comorbidity. The number of chronic diseases affects functional health and quality of life. Therefore, those advanced in age are especially prone to functional limitations and need care and support. In order to minimise the disruption to patients’ lives from chronic disease, it is imperative to expose them to adaptive devices such as adherence to medication, proper diet and physical activity.

The adaptive strategies to enhance functional capacity are influenced by medical advice. Positive attitudes, beliefs, and practices of patients are the result of regular attendance to the hospital for care and support. As society continues to focus on the medical causes of these chronic diseases, community participation and involvement are measures for the success of prevention and control of chronic diseases.

4.4 Factors that contribute to chronic diseases among the elderly in the study area

The thematic network below displays patients’ understanding of factors contributing to chronic diseases. The numbers attached to each of the contributing factors for chronic conditions in the thematic network represent the number of participants who mentioned that a particular chronic disease was caused by these factors.
Fig. 3. Factors that contribute to chronic diseases among the elderly in the study area

4.4.1 Factors that contribute to chronic diseases among the elderly by key informants

The thematic network below shows the interviewed medical professionals’ understanding of factors that contribute to chronic diseases among the elderly in Akim Oda. The numbers attached to each of the factors contributing to chronic diseases in the thematic network represent the number of key informants who mentioned that those factors cause chronic disease.
Chronic diseases were attributed to seven causes by study participants: heredity, physical inactivity, poor diets, poor lifestyle practices, physical, hypertension, pregnancy, and psychological or stress-related factors. Patient knowledge and medical expertise on causes of chronic diseases were revealed. The medical expertise held sufficient biomedical knowledge on causes of diabetes, hypertension, and stroke. These are also shown in the voices below.

### 4.4.2 Poor Diets

There were three sub-topics to the role of diet regimen in diseases. In the first place, all participants connected chronic diseases to chronic diseases. Specifically, the utilization of high sugar, high fat, and starchy diets were among those recorded. Study participants likewise indicated contemporary westernized diets, such as, canned nourishments, spread, flavourings.
(e.g. Maggie cubes), fatty foods, and sweets like ice cream as causes of their conditions, while others attributed the causes to eating late in the night and too many carbohydrates. The voices below from some of the study participants indicated the relationship between eating habits and diabetes.

*I was told by the doctor that eating food like fufu and banku late at night increases the likelihood for my sugar level to increase, since the food is stored as sugar in my body* (Female, Diabetes Participant).

*The nurse said it is cholesterol and too much eating in the night. Sometimes I had to wait for my husband before I eat, and he always comes late. Immediately I finished eating I felt sleepy, so I had to go to bed* (female, Hypertension Participants).

The statement under from two of the key informants confirmed lay knowledge about the causes of chronic diseases.

*If you don’t eat healthy and eat a lot of fast foods, all that it can lead to is high cholesterol in the system, if it goes on and on it will narrow the vessels where the heart will be forced to pump harder than it should be and can lead to hypertension. Poor diet can lead to high blood pressure, and if it’s not controlled, it can lead to stroke* (Male Doctor).

*The human system needs balanced diet to work effectively. As a nurse I know that vitamins boost immune system and lack of some vitamins in the human body may cause deficiencies. For example, if the diet is lacking minerals, one may not be able to fight diseases when the immune system is been attack. There is the need to make the immune system strong otherwise the least infection can cause trouble to the immune system. Some of the patients also eat late in the night and go to bed immediately which can also block the veins and can cause a lot of harm to the body. My experience with some of these patients in this hospital shows that, like of these vitamins may contribute to chronic diseases* (Male Nurse).

**4.4.3 Poor Lifestyle Practices**

References to poor way of life practices like drinking and smoking, were made by a portion of the study participants as the primary cause of their chronic conditions. There are a few synthetic compounds in cigarettes that are bad for the body, and even the manner in which mixed beverages are refined with a wide range of synthetic substances can cause
chronic conditions. In any case, when one ends up dependent on it, it is extremely hard to stop. Drinking, smoking and different medications could annihilate one's wellbeing and can cause chronic conditions. The patients quoted below explain the relationship between their personal lifestyle choices and the chronic diseases they now experience.

"I used to smoke when I was at a very tender age. I started smoking in 1970 and I smoked for a period of three years but put an end to it when I was about entering the tertiary institution. I started again because of the stressful nature of my job, which also contributed to my intake of alcoholic beverages (Male Diabetic Patient)."

"Drinking of wine and other local gin a lot, my son I can tell you that I have drank for the past 25 years, which I think have been the main contributing factor for the high blood pressure (Male Hypertensive Patient)."

These assertions are confirmed by two key informants.

"Smoking and drinking cannot directly cause stroke, but it can bring in the risk factors. Smoking too can cause hypertension and drinking can predispose one to diabetes. Especially when it becomes chronic to the point that the liver is affected and the Pancreas too gets involved and cannot regulate the insulin production. This can also lead to high cholesterol. People with high cholesterol, if not controlled it can lead to stroke. (Male Doctor)."

"Smoking and too much alcohol has effect on the liver. Excessive alcohol destroys the liver which is the factory of the body insulin. The pancreas produces the insulin for regulation of sugar and if you destroy the pancreas, then little defensive insulin is produced and that can cause diabetes (Female Nurse)."

4.4.4 Heredity

Another theme that emerged was that some chronic diseases were hereditary. Conditions like diabetes and hypertension were linked to family histories. Some participants had family members with these specific conditions. Some study participants, like the patient quoted below, indicated clearly that they acquired diabetes by inheriting it from their families.

"To me, diabetes is hereditary which means that it can be transferred from parents to offspring. My father suffered from diabetes, my elder brother is suffering from it and I am also suffering from it right now. There are other extended family members with
diabetes, hence my belief that it is hereditary. I inherited it from my father because most of his family members are diabetic (Male Diabetic patient).

On the other hand, one may become diabetic even without a family history, as another patient explained.

I think diabetes is caused by the lifestyle of the people who have it. I believe my lifestyle was not the best, especially in terms of my eating habits and that could be the reason why I contracted the disease in the first place. I used to eat anyhow, a lot of fat, oily foods, and alcoholic drinks, but I have now been restricted to certain foods that would aid my quick recovery (Male Diabetic Patient).

Key informants also confirmed that some of the chronic diseases are hereditary, but the disease may not manifest itself without some social or environmental factors contributing to it. Key informants are quoted below.

The chances are that one can inherit these genes from parents. But as to whether the genes will manifest into diabetes one may have environmental factors coming into play. For instance, a first-degree member who has inherited those genes from your parents, and knows one can get diabetes, and you don’t take very good care of yourself, and keeps on drinking alcohol, you will by all means contract diabetes or any inherited chronic condition easily. If it is genetic they can transfer the genes to their children (Male Diabetic Patient).

Basically, there is a genetic predisposition. If your parents have the chronic condition, it predisposes you to it. From my experience, most patients who present diabetes and other chronic diseases have a history of the disease in their families (Male Diabetic Patient).

4.4.5 Stress-Related Chronic Diseases

Stress-related chronic diseases were identified as one of the contributing elements to chronic disease in the participants of the study and were discussed in relation to mental and emotional states. The role of social variables was emphasized. Study participants noticed that diseases with mental causes were traceable to social and financial issues and dangers from their spouses. For instance, disturbed family connections or dangers from the spouse prompted excessive anxiety and stress. This emotional stress also manifested physically.
Heart diseases and hypertension were connected to psychological risk factors. Over-thinking and fear could cause heart disease. A few male informants expressed the conviction that their marriages had been major contributing factors to their chronic conditions. As these participants explained it, after losing their employment, the threats and insults they received from their spouses culminated in mental stress that resulted in their chronic conditions. Some of the females also attributed their chronic conditions to over-thinking, stress and fear caused by their husbands constantly threatening to kill them. This was confirmed by some of the study participants below:

Too much thinking, when you are embittered because of a problem. My wife has been the cause; she worries me a lot and made me think. My wife was giving me problems that made me think and I know because of her troublesomeness that has led me into this situation. Money was not coming as it used to be and I also lost my job and the insults were too much. She even divorced me immediately I contracted stroke (Male Stroke Patient).

My husband threatened to kill me, made me think too much, and I was always afraid for my life. Constant threatening led to this stress and the doctors told me that quarrelling with my husband regularly contributed to my hypertension (Female Hypertensive patient).

4.4.6 Pregnancy

It also emerged in the study that pregnancy can be a contributing factor for diabetes. The predisposition for diabetes may be genetic and hidden, and only pregnancy can cause it to manifest itself. Some hormonal changes during pregnancy can also cause diabetes. According to the medical experts it has to appear three consecutive times during three different pregnancies, and then it comes to stay with you. The voices below from key informants elaborate on the above.

Some women experienced diabetes as a result of pregnancy—we have types one, two and three but the type three is normally what they get during pregnancy (gestational diabetes). It is genetic and may manifest itself during pregnancy. Hormonal changes can cause diabetes from the 6th to the 7th month. The symptoms go down after childbirth or may disappear until the next pregnancy before symptoms begin to
manifest themselves again. During the third pregnancy, the diabetes may come to stay with the woman as a permanent condition (Female Nurse).

There can be diabetes in pregnancy. It is called gestational diabetes. It is the pregnancy makes the person diabetic, when the pregnancy terminates, the person becomes well again. It is caused by the hormones that are produced during pregnancy. The progesterones, estrogens, they are diabetogenic: that means they cause an increase in sugar in the blood just to make the sugar available for the developing baby. They cause decreases in sensitive peripheral cells of the mother to insulin. So, the insulin may be there, but may not be adequate for the mother to use the glucose in the blood. When these two factors come into play, a situation arise where we have more sugar remaining in the mother’s blood and that predisposes her to the diabetic condition (Male Doctor).

4.4.7 Physical Inactivity

Physical inactivity was one of the themes that emerged from the study. Physical activity is characterized as 30 minutes of light or moderate physical exercises at once for at least five times each week, or 20 minutes of incredible exercises at once for at least three times each week. Hard physical labour and energetic strolling can be characterized as overwhelming and moderate physical exercises, respectively. Few of the study participants identified physical inactivity as one of the major causes of their chronic conditions. However, a few of them indicated that they have not been doing any exercise at all and think this might have contributed to their chronic condition. The voices beneath describe patient views of physical (in)activity and chronic disease.

I used to exercise in the past, (playing football, jogging and aerobics) but for some time now I have stopped. If I could remember, for the past 15 years, I have not done any exercise to burn fat which caused my high blood pressure, which, in turn, led to my contracting of stroke and diabetes (Male Diabetic Patient).

I think also I was not doing exercise, living sedentary lifestyle. Sitting in my vehicle everyday even short distance, and I believed it has been a major contributing factor, but now after experiencing chronic diseases I do a lot of exercise to burn fat, so my hypertension will not go up for me to have stroke again (Male Stroke Patient).
4.4.8 Hypertension

One theme that emerged out of the analysis was hypertension as one of the known intermediate threat factors for non-communicable diseases. Participants of the study differently showed having a raised pulse of $>140\text{mmHg}$ and diastolic weight of $>90\text{mmHg}$, taking anti-hypertensive medicine, or being diagnosed as hypertensive by a medical specialist in the past a half year. Some of the elderly people had their circulatory strain estimated by a specialist or medicinal services worker at the Akim Oda Government Hospital in the past 6 months and had been diagnosed as hypertensive, which was uncontrolled and which they believed led to their stroke. All of the study participants who were on prescribed anti-hypertensive medication confirmed that they had the disease, and all the stroke patients indicated that it is the rising of their blood pressure that led them to stroke. The voice below from one stroke patient explains his experience.

*I experienced this at the clinic, and the medical attendant told me that my pressure is high, and if I don’t take care I could have a stroke. She prescribed some medicine which I took but in no mean time I had a stroke* (Male Stroke Patient).

Hypertension was identified as a major cause of stroke by all key informants.

*The commonest cause of stroke cases in the hospital is through systemic hypertension where the patient comes with the BP very high, sometimes above 180mmHg/110. In some cases, this happens alongside the loss of consciousness, where the patient cannot talk, respond, or is confused or has some weakness in some parts of the leg either the left or right side. Other symptoms include; facial palsy, there is a defect or damage in of brain, which sometimes ceases to function or experiences limited functioning* (Male Doctor).

*Hypertension is the commonest cause of stroke cases reported to this hospital and all the stroke patients we have now are as a result of uncontrolled hypertension. We have those who are known to be hypertensive, which means they have been diagnosed and on treatment and we have those who are just diagnosed after they experience the stroke. It happens such that the blood pressure goes very high and if the pressure goes beyond what the artery can take, it will rapture or burst. Other risk factors may be heart disease. The patient might have high cholesterol which can lead to narrowing the blood vessel, and when the blood vessels become narrow, it gets to a point that it clots, and blood cannot pass through. Beyond the point of occlusion, there is no blood*
supply and with time, the brain cells start to die off which can cause stroke. That is the link between hypertension and stroke (Male Doctor).

4.4.9 No Knowledge

No information was one of the themes that emerged out of the information analysis. A portion of the study participants said that they have no information about the reasons for their chronic conditions. Some of them were admitted at the Akim Oda Government Hospital and were told after lab results that they had the chronic disease. A few felt sick in the house and were rushed to the hospital. Below, three patients describe their confusion over the causes of their chronic communicable conditions.

I am divorced for the past 15 years and don’t really know what is wrong with me. I stayed with one man after separating from my husband, but later I discovered that the man had a wife, so I separated again. Since then I have never gone near any man again. The man I married to does not have HIV/AIDS, the man I stayed with some years back does not have HIV/AIDS and he is still staying with his wife. So, I don’t know where I got the HIV/AIDS from (Female, HIV/AIDS Patient).

I don’t know, I was just told in this hospital that I have HIV/AIDS. I don’t really know what the cause of this HIV/AIDS was. My husband whom I divorced is still around and strong and has no HIV/AIDS. He is not suffering from any diseases. I don’t really know how and when I came in contact with this HIV/AIDS. I married this man from a young age, and I don’t really know why and when I contracted this disease. From childhood I have had stomach problems. Lately I had a stroke and half of my body was not working, it was through that I got to know that I have HIV/AIDS. I don’t know where I came in contact with this disease (Female, HIV/AIDS Patient).

I don’t know what causes the HIV/AIDS in me or how come I contracted the disease. I was not aware and do not known as of now how I contracted this disease. Either it is from womanizing or whatever I don’t know, I was told by the doctors when I was admitted (Male, HIV/AIDS Patient).

4.4.10 Discussion of Factors Contributing to Chronic Disease

For most medical experts, diabetes is understood to be the result of hereditary qualities; poor way of life conduct, including poor dietary patterns; excessive liquor consumption; and physical idleness. Individual patients attribute the reason for diabetes to
excessive smoking, eating too many carbs, physical inactivity and unnecessary liquor consumption. A study conducted by Australian health survey (2014), which found that chronic disease is regularly examined in relation to four categories: cardiovascular diseases, cancer, chronic obstructive pulmonary diseases (COPD) and diabetes, with four common interactive risk factors: smoking, physical idleness, poor nourishment and unsafe liquor consumption (AIHW 2014). An investigation led by Aikins et al. (2010) attributing Africa's chronic disease load to multifaceted components, including way of life practices, was likewise affirmed, since poor way of life was recognized as a causal factor in this study. However, urbanisation and globalization were not identified as causes here, in contrast to the study by Aikins et al. Also, research by Mirrakhimov (2012) concluded that there are common risk factors for chronic diseases such as air pollution, ageing, respiratory tract infections, bronchial asthma, poor socio-economic status and smoking. In the present study, air pollution, bronchial asthma, and respiratory tract infections were not identified as causes of chronic diseases by study participants, but smoking and poor socio-economic status were revealed as causes of chronic diseases in Akim Oda. Research by Steyn and Damasceno (2006) revealed that certain lifestyle and behavioural characteristics of individuals also have the tendency to contribute to the pervasiveness of chronic illnesses such as diabetes, hypertension, stroke, and cancers. The case of Akim Oda also aligns with these findings. Both expert and patient participants held sufficient biomedical knowledge on the causes of diabetes. This knowledge, when translated into behaviour, will make diabetic patients prioritize drug treatment and diet management. Hypertension was identified by both experts and elderly with chronic diseases as the major cause of stroke. Its management can be very expensive depending on your social status, in agreement with a study by Akins (2007), who indicated that in Ghana, the cost of controlling a condition such as hypertension is greater than the average individual income. This tends to move low-income families into the worst
poverty situations. In the case of Akim Oda, however, many patients indicated that they received hypertension medication free-of-charge, alleviating some of their stress in managing the condition.

As per specialists from Australia, financial conditions and the stress of other hardships make patients vulnerable to hypertension, and, if left untreated, this condition can lead to stroke (AIHW 2014). Diets, excessive liquor consumption, and other destructive lifestyle choices have been distinguished as reasons for hypertension by study participants. Similarly, a study by Wikman et al. (2011) found that being diagnosed with a chronic disease prompts agonizing encounters that influence the general wellbeing of the elderly. Another study directed by the National Institute for Health and Clinical Excellence (2011) found that individuals with chronic hypertension tended to have abnormally high levels of hypertension, a noteworthy causative factor in diseases, such as, stroke, kidney diseases chronic cognitive deterioration and sudden death. Though one patient had information on the reason for HIV, she didn't know about the source of her disease. Critically, as the individual did not realize what caused the HIV, she might be prone to seek single health practices, ranging from biomedical, ethno-restorative and faith mending healing networks, contingent upon her access to these diverse services and financial status. Hypertension, diets, physical inactivity, excessive thinking, genetics and womanizing were reported to be associated with stroke. This suggests a high knowledge of the causes of stroke by both the patients and experts. It is general knowledge among both the patient and expert that prevention and control of hypertension is imperative in that complications of the disease can lead to stroke.

4.5 Challenges encountered by elderly living with chronic diseases in study area

The thematic network below demonstrates challenges encountered by elderly persons living with chronic diseases in Akim Oda. The numbers attached to each of the challenges identified by the study participants in the thematic network below represent the number of
elderly who mentioned or are experiencing these challenges as a result of their chronic conditions.

Fig.5: Challenges encountered by elderly living with chronic diseases in study area

The idea of biographical disturbance has been utilized as a descriptor of individuals' encounters with chronic diseases. The study has demonstrated that chronic diseases, such as hypertension, diabetes, stroke, and HIV, imperil physical, and emotional wellbeing to the degree that an individual turns into a stranger unto themselves. Moreover, findings reveal that individuals were faced with mobility challenges, divorce, ignorance and deception, visual impairment, neglect by family, sexual weakness, economic, institutional, social challenges and ultimately death. These economic and social disturbances can happen even with regards
to solid family and social help and undermine any medicinal connections (Young et al., 2009). These challenges are illustrated below.

4.6 Challenges Encountered by Elderly Living with Chronic Diseases in Study Area

4.6.1 Social/Functional Challenges

Social/functional challenges identified by study participants were mobility, divorce, visual impairment, neglect by family and friends, sexual weakness, and exploitation by some religious leaders. Mobility emerged as one of the challenges faced by study participants. Participants of the study, especially those suffering from stroke, expressed that they are deformed and cannot perform most of their daily tasks without the assistance of other people. According to Bury (1982), chronic illness constitutes a disruption of an ongoing life. The present daily routine is hindered, possibly obstructed altogether. The life of a person living with a chronic disease is totally troubled and full of indecisions, and the condition draws the ill person’s focus to the bodily state.

4.6.2 Mobility challenges

Both male and female participants shared that mobility has been their greatest challenge. The findings of the study also indicated that individuals diagnosed with chronic diseases for over five years have accepted their condition and its challenges and have developed coping strategies. On the other hand, those diagnosed with chronic diseases less than 5 years ago still feel their current condition is not their real identity and continue to search for cures to their chronic conditions. The search has led most of them to move from one hospital to another, church to church, and from one traditional healer to another. They are still rethinking their identity, which is no longer compatible with their perceived normal trajectory. This confirmed the predictions of Bury’s biographical disruption theory, which says that the disturbance from chronic diseases extends to people’s explanatory systems. This prompts a rethinking of identity and self-concept. The life of a person living with a chronic
disease is completely disrupted and full of uncertainties. Study participants identified that they cannot perform most of their daily household chores and can’t even take their bath. Two participants quoted below express frustration with their limited mobility.

*I can’t write because I can’t use my right hand. I can’t use the right hand for anything and cannot even move it up. It is totally inactive and can’t even wash my own clothes (Male Stroke Patient).*

*I always walk with the help or support of sticks and sometimes I hold on to the wall. I can’t walk without the help of my wife. Someone has to take care of you in all your domestic needs (Male Stroke Patient).*

This was also confirmed by one of the key informants.

*These patients sit in their various homes for their chronic conditions to escalate before they come to hospital. Go to the male ward to bed seven and see for yourself. We have an old man there whose toes have been taken out because of diabetes. He is lucky he came to hospital. If he had spent one more week home the whole leg would have been amputated (Female Nurse).*

### 4.6.2 Divorce

Study participants shared that one of their major challenges is divorce. Both the male and female participants share their challenges with their spouses. Most of the participants shared that since the time they contracted the chronic diseases their spouses have separated or divorced them and left them alone. This was a challenge for both male and female. The statements below from a male and a female participant describe the strain their illnesses placed on their marriages:

*At times your wife and children too neglect you. My wife has divorced me because of my stroke and my own children I don’t even see them anymore. I never knew my wife would do that. She is not married but flirting around. My sickness was her reason for divorcing me (Male Stroke Patient).*

*I have to fight on my own. My husband separated from me because of my sickness. He was not coming home early after work. I talked, and he got upset and opted for divorce, which I accepted (Female Hypertension Patient).*
The key informants identified divorce as one of the challenges they often see, and they have tried to settle most of the cases.

Some men even divorce their wives because of their chronic conditions and we have to help them out. We have solved more than ten cases and all the complaints are from women that their spouses want to leave them. Some of them need family support. As I said earlier on, the women don’t have the libido to have sex and men as old as 70 still want sex and causes confusion in their marital homes (Female Nurse).

4.6.3 Visual Impairment

Visual impairment as a functional challenge was one of the themes that emerged during the analysis of data. A few of the study participants indicated that they are either partially or fully blind as a result of their chronic conditions and cannot do anything at all. They complained that they cannot see even things near them and always have to call for support. Both males and females attributed their visual impairment to their chronic conditions but not as a result of age. The statements below illustrate this theme.

I also attribute my blurred vision to diabetes because I could see clearly before I contracted the disease (Male Diabetic Patient).

I have a problem with the eye. Now I have a problem with my sight due to this disease. Though I have problems with my sight, my grandchild who is helping me may leave for further studies (Female Stroke Patient).

Key informants also indicated that diabetes, stroke and hypertension can lead to blindness.

Diabetes and hypertension causes blindness if not controlled. Diabetes has some complications. It causes blindness. It is the sugar in the blood that causes blindness (Female Nurse).

4.6.4 Neglect by family and friends

Neglect by family members and intimate friends are some of the themes that emerged during the analysis of data from Akim Oda. Study participants shared that they have been neglected by their family members and their intimate friends. Some shared that with friends and family members around them, they feel good and always happy that others are there for them. Some expressed that none of their friends or family members visit them anymore and
some find it difficult to adhere to their hospital schedules and attend hospital alone. It seems all their children, siblings and relatives have given up on them because of their chronic conditions. Most of the males were with the view that their family members and even their own children have left them because of their chronic diseases. Most of the female participants were staying with their children, but the males are either with a helper or their spouse. Study participants indicated that this was the time they need love and care and support from their friends and family members, but it seems it is the time that family members and friends have neglected them. This can be seen in the statements below.

**Sometimes your wife and children too neglect you. First, I was in the same bedroom with my wife, but now she has moved to another room because of my chronic condition (Male Stroke Patient).**

**Initially my friends were supporting me, but they have all stopped. My son forgets about me, and there is no support from anywhere, and they have all abandoned me. Even my family members are tired. Now my neighbor’s daughter is the one who assist me (Male Stroke Patient).**

This is also in agreement with what key informants said about the neglect of elderly persons experiencing chronic disease by family members and friends. Below, key informants describe the dynamics they have often observed between elderly chronic disease sufferers and their families.

**Sometimes the elderly become bedridden with the chronic disease especially the stroke patients. If the family members are not forthcoming in terms of food, and medication it makes it difficult to take care of them. We can’t take care of the patient without the relatives. Sometimes you become depressed looking at some patients. Sometimes we try doing some of the things at the ward for them. When the patient feels alone and lonely, depression sets in, so the care from the family is very important. Relatives can bring patients two weeks and will not show up again. We have some stroke patients here who are now well, but no one is even coming for them because they are afraid of the hospital bills (Female Nurse).**

**Most of the time, once the patient comes to the ward, the relatives don’t come anymore. We have to be taking care in terms of their medicine and food. One man was left here even after the hospital has discharged him (Male Nurse).**
Some patients who were on admission were at the hospital alone, and some were admitted as a result of not taking their medication as prescribed by the doctor—a problem that could have been prevented with family assistance. Some even stop taking their medication immediately they see that their chronic conditions have improved a little. The findings below explain this.

Some default and it can lead them to so many complications. They sit in the house or they can wait and come at any time, when they see that their situation is becoming worse (Female Nurse).

Some come to the hospital alone, some when you call them, they cannot even hear, the nurses have to take charge of everything. Even when they have to go for labs, the nurse has to do it. In some situations, you can’t find the relative at all, the hospital comes in, in terms of medicine and other support (Male Nurse).

4.6.5 Sexual Weakness

Sexual weakness was one of the themes that came up, and study participants expressed their worries about how it is affecting their relationships with their spouses. The men complained that they cannot get an erection and cannot have sex with their wives. The women shared that they do not also have the libido to have sex with their husbands, which is also ruining their marriages. Sexual weakness has resulted in separation of marriages, a challenge about which both male and female study participants shared their worry. Below are statements that exemplify this theme.

My sexual drive has been weakened due to my diabetes and high blood pressure. Sometimes I don’t even have the urge to have sex. I experience waist pains and find it difficult walking properly (Male Diabetic Patient).

When you have stroke, you lose your manhood. I have lost mine and can’t do anything again. Because of this sickness, I can’t do anything; we can’t have sex (Male Stroke Patient).

4.6.6 Economic challenges

Some of the study participants cited financial problems as their greatest challenge in dealing with their chronic diseases. For some, their chronic conditions have led to loss of employment, bankruptcy, and loss of properties. Some also expressed that the cost of both
herbal and pharmaceutical medication has been their greatest challenge, since they cannot afford most of their medication. Transportation costs to hospital, cost of physiotherapy, and inadequate pension benefits were also identified as some of the challenges faced by the study participants. The interview excerpts below describe some of these obstacles.

*I need support in medication, day to day financial support. I spend about 13 thousand Ghana cedis every month. I have gone bankrupt hence have no money (Male, SP.1).
*I have taken a lot of money from my children and I have also used all my pension money to battle this disease and don't have enough now (Male Stroke Patient).

Majority of study participants were on pension and expressed that the amount they received for their pension benefits was not enough to take care of their needs. They shared that the pension money is too small even to cover their medication. Some men explained that at their age they still give housekeeping money and also have to take care of their medication and other expenses. This is what two participants had to say:

*I am a pensioner and at the end of the month I receive something small. Pension pays 500 Ghana cedis a month and cannot even buy my medicine. Now I have become a burden on others (Female Stroke Patient).

*My monthly pension allowance is nothing to write home about, only 328 Ghana cedis. I have nothing in my account, this disease has ruined me financially and my son, and this is the main source I get money for my medication, food, and others (Male Stroke Patient).

The key informants also identified some of the challenges faced by the institutions in dealing with elderly persons living with chronic diseases. Some of the challenges identified were ignorance and deception, premature death, attending hospital late, default in medication schedule, attending hospital alone, dementia, and neglect by family members.

4.6.7 Ignorance and Deception

Ignorance and deception were identified by key informants who complained bitterly that some of the patients are being deceived by some religious leaders who capitalize on their conditions and extort huge amounts of money for prayers. Herbalists also offer herbal
medication without calculating the appropriate dosage. The statement below explains the problem.

*With traditional medicine one cannot know the right dosage to be taken because many of them have not yet been tested to find out how much the body needs. It has also been causing a lot of trouble for us. One woman came with pilled body and nearly died. Others have died out of ignorance and deception from those traditional people (Female Nurse).*

Some of the study participants also perceived their chronic conditions as spiritual and think they need spiritual solutions for the challenges they are facing. Due to this, some religious leaders have capitalized on their diseases and exploited them without having any solution to their problems. Both men and women shared how, at the beginning of their chronic conditions, they rushed to several pastors, prayer camps, and spiritual men for solutions but to no avail. Below are the voices of two study participants.

*I have also spent money on pastors who claim to have the power to make my sickness go away. In fact, I spent over GHS 3,900 on one pastor at Koforidua some months ago when my condition became critical. I have visited several pastors and Men of God but all to no avail (Female Diabetic Patient).*

*At times, I visit prayer camps because I know that this is spiritual. At times your mind tells you to get spiritual support, which forces you to go for the support from these pastors and it is not for free. At times I visit them weekly and at every visit you have to pay money. I have paid too much that I can’t recollect and have decided not to visit any prayer camp or pastor again (Male Stroke Patient).*

### 4.6.8 Premature death and attending hospital late

Premature deaths and attending hospital late were major concerns for the experts. They confirmed that some patients stay in their homes until their situation escalates before they come to hospital. Some come and die immediately or spend a few minutes at the hospital and die. This can be seen in the responses below.

*They don’t bring the patient early to the hospital, and most of them come in a bad state. They wait for the patient to be unconscious before they bring them, and most of them don’t spend much time and die. Reporting to hospital late and relatives not*
showing much concern when the patient is admitted are some of the challenges we face (Male Nurse).

Some come with big ulcers. They sit down for things to escalate before they come. We have a boy here whose toes have been taken out. Sometimes it pains me that you see them coming in a bad state, but at the end you feel that joy when some of them begin to recover (Female Nurse).

4.6.9 Secrecy

Secrecy is one of the themes that emerged during the data analysis. Some participants of the study showed unwillingness to disclose to their friends or family members that they have chronic conditions. Study participants with HIV/AIDS shared that the stigma in society and how people treat them when their chronic condition becomes public is why they keep it secret. Some of the HIV/AIDS participants are the only ones who know their health conditions, along with some few trusted family members. This can be seen in the responses below by two HIV/AIDS patients.

It is only my elder daughter who is aware that I have HIV/AIDS, and the rest are not aware. I trust my daughter will not share with anyone. I know my daughter will not share with anyone. I trust her so much and she has never shared with anyone. As I told you, I have five children, and she is the only one I trust. That is why she is aware and also, she was the one who took me to hospital and was diagnosed HIV/AIDS positive. Since no one is aware of it, I am okay, and everyone is okay with me. (Female, HIV/AIDS Patient).

I informed only my sister and she has kept it from friends and relatives. None of my family members is aware. You know it is worrying and the stigma attached is strong which is why you can’t inform any one. If you do that, they may not even want to eat or do anything with you. So, I will not inform anyone (Female HIV/AIDS Patient).

4.6.10 Discussion of the Challenges Faced by Elderly Persons with Chronic Disease

A few individuals experienced interruption to their lives as an outcome of chronic diseases, and others likewise experienced chronic diseases as a risk to their identity. The study features the significance of identity, showing that illnesses that affect personality and basic faculties constitute the most extreme biographical disruptions. For example, immobility
or augmented brain function, as can occur with diseases like stroke and diabetes will deny him or her autonomy, which may deter them from taking productive interest in social interaction.

The majority of the study participants who have had the chronic diseases for at least five years and over have different experiences from those who have had it for two years or less. For example, some of those with chronic diseases for more than five years have experienced loss of employment leading to bankruptcy, loss of properties and financial problems. Some complained of inadequate government support. Study participants who are below 70 years complained bitterly that ageing and managing chronic diseases is becoming more expensive as the National Health Insurance Scheme does not cover them. This may render ageing very expensive with little or no support for the elderly, and many of the elderly are driven into poverty; some even wind up selling their properties. This is in support of a study by WHO (2010) which claimed that every year, 100 million people are plunged into poverty because they have to pay directly for the health services needed to treat diseases like stroke, hypertension and diabetes. Also, the report from Kruk et al, (2009) indicates that direct payments from patients still account for more than 50% of total health expenditure in a large number of low- and middle-income countries. This means that more than half of total health spending in these countries comes from people’s pockets. Findings also revealed that one in four families living in the world’s poorest countries borrowed money or sold assets to pay for medical care of their chronic conditions (Kruk et al, 2009). This is because the National Health Insurance Scheme in Ghana gives exception of premium payment to those aged 70 and above, leaving those between 60 and 70 years to their fate, despite the fact that 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. One of the study participants suffering from stroke and hypertension said
he lost a vast land he bought, because he has been bedridden for three years. The children of the man he bought the land from have sold it to other clients. Some of those who have had the conditions for two to three years still have their marriages intact; their social relationships are strong, and friends visit their homes, unlike those who have had it long and friends are even tired of them. The consequences of the unstable psychological and emotional state of patients are that these experiences could predispose them to cardiovascular diseases and premature death.

The findings confirmed the biographical disruption theory by Bury (1982) that chronic illness constitutes a disruption, a discontinuance of an ongoing life. The discoveries of this study are in concurrence with research discoveries of de Gusmao, Mion and Pierin (2009) that chronic diseases have progressively become more normal and now make-up the majority of the disease burden. Chronically ill patients may experience significant decline in quality of life and even death due to their permanent condition. The discoveries from this study resonate with the findings of the WHO (2005) that the lives of an increasing number of people around the world are disrupted by chronic diseases, including heart disease, stroke, cancer, chronic respiratory ailments and diabetes.

The study found that cost of managing chronic disease, including its mundane aspects like transportation to the hospital, is very expensive. Some of the individuals could not afford these expenses, because they were unemployed. Thus, the cost of pharmaceutical medication may account, in part, for an individual’s inability to care for and manage chronic diseases. This may clarify the findings of WHO (2005) that chronic diseases sufferers in low- and middle-income nations tend to experience the ill effects of their chronic diseases regularly, with preventable complications and die sooner than those in higher income nations.

In addition, most of the study participants have stopped working due to the disruption of chronic diseases. Individuals suffering from HIV, stroke, and hypertension have lost their
jobs due to the nature of the chronic disease. This has consequently made it difficult for individuals to meet basic needs, and they have had to depend on family, friends, and the general public. The findings show that most men do not have their children taking care of them, but the female patients tend to have their children supporting them in their daily activities. Few of the study participants were staying with their spouses. Some are separated and stay either with their wards or servants. Besides, the lack of support from relatives makes it difficult for patients to discover their self-identity, assert independence and give meaning to the own lives. The experiences of men were different from those of women in this regard, since most of the male study participants were pensioners and are receiving pension benefits. They could afford some of their medication, but most of the female elderly who were not receiving any pension benefits were relying solely on their children and siblings. Some of the females have to even go and beg by the road side for alms before they can get something to eat, because they are divorced. Most of the study participants have uncontrolled hypertension, which has led to stroke and other chronic diseases. This is in concurrence with a study by Wikman et.al. (2011) which found that being diagnosed to have a chronic condition prompts troubling encounters that affect the person's effective well-being. Another study by the National Institute for Health and Clinical Excellence (2011) found that individuals diagnosed with chronic hypertension tend to have increasing hypertension levels.

4.7 Coping Strategies adopted by elderly persons living with chronic diseases

The thematic network below displays coping strategies adopted by elderly persons experiencing chronic diseases in Akim Oda. The numbers attached to each of the coping strategies in the thematic network represent the number of elderly with chronic diseases who mentioned that they adopted such strategies to cope with their chronic disease.
Fig.6: Coping Strategies adopted by elderly persons living with chronic diseases

There are specific efforts, both behavioural and psychological; that elderly persons with chronic diseases employ to master, tolerate, reduce or minimize stressful events associated chronic diseases. The study found that the extent to which elderly persons managed their chronic diseases were varied. It noted that some participants relied on family support, social support groups, adherence to prescribed food and medication, use of walking aid, rest and physical exercises as a portion of the techniques to adapt to chronic diseases. The strategies for coping shared by study participants were grouped under two main themes, namely material support and symbolic support. The latter can include social support strategies, like nurturing connections with friends and family members and building relationships with health professionals, religious bodies and the media.
4.7.1 Material Support

Most of the study participants received material support from their social groups, such as church, and other family members, friends, selling of farm products, savings and pension benefits, and support from government. Below are participants’ own words.

My husband and my daughter always supported me to attend hospital. They give me money anytime I need it for hospital. Some of my family members come to console me, stay with me, and I am always happy (Female Stroke Patient).

I have been receiving support from my children, and sometimes, if I don’t have anything and have to come for medicine at the hospital, I can ask my friends and they assist (Male Hypertensive Patient).

One of the key informants also confirmed that the hospital authorities also assist patients to cope with their chronic diseases. As one nurse explained:

We used to have a welfare scheme but now it is no more in existence. The hospital has discharged a lot of people free of charge. Sometimes we use our own money to support some of the elderly in this hospital. The only thing the social welfare unit in the hospital does is to go and look for their relatives in their hometowns (Male Nurse).

Adherence to prescribed food and medication, physical activity, rest, media, weeping, reliance on God or spiritual upliftment, social interactions, wearing of nice dresses, rest or sleeping, listening to music, preaching and reading both religious and secular books are some of the strategies adopted by the study participants.

4.7.2 Spiritual Upliftment or Reliance on God

Many of the elderly in the study are weak or frail, unlike their youthful days, they depend more on God as a way of comforting themselves, since they are unable to perform functions they used to. In whatever problem they face, they have a strong belief that God will intervene. In the excerpts below, participants described such coping strategies.

I also sing to keep myself entertained and pray to God to grant me the strength to go about my daily activities (Female Diabetic Patient).
I always rely on prayers when I am alone, and my women’s group in church also visit me regularly and pray for me (Female Stroke Patient).

I also pray and read my Bible whenever I feel lonely or bored, and I know the good Lord will heal me fast (Male Stroke Patient).

4.7.3 Social Interaction

Some of the participants find comfort spending time with their friends or age mates. The mobile ones visit their friends a lot in order to discuss problems and chat with them when they feel sad or neglected, which makes them become happy. Some even interact with their children, grandchildren and spouses. Some of the elderly in Akim Oda find solace in their friends or cohorts; hence they prefer visiting them in their homes or having their friends coming to visit them. Below are statements that illustrate this theme.

I always sit and chat with friends to keep me entertained when I am bored (Female Diabetic Patient).

Most of the time I sit down with my father’s wives and other relatives to discuss the word of God. My daughter and grandchild are now helping me, and we converse a lot. My grandchild always comes to converse with me, which makes me happy (Female Stroke Patient).

4.7.4 Media

In discussing chronic disease management and coping strategies, some study participants shared that they solely relied on media entertainment anytime they feel lonely and neglected. They indicated that listening to music, preaching on radio and television, and reading both religious and secular books when they are bored has helped them a lot. The statements below describe media-based strategies of coping.

I watch television a lot especially when there is church service, children’s programme and movies, since I can’t go anywhere (Female Stroke Patient).

I listen to music as well as the news on my radio to keep myself entertained anytime I feel neglected and bored (Male Diabetic Patient).
4.7.5 Adherence to Prescribed Medication and Diet

Some elderly persons in Akim Oda also indicated that they have never defaulted and adhere strictly to the food and medication regimens prescribed by their doctors and nurses. This has really assisted them to cope with their chronic conditions. The statements below are indicative of this theme.

*In feeding, I am careful and always make sure I don’t eat what doctor has told me not to eat (Stroke Patient).*

*No salt and fresh meat in my food, and make sure I eat before 6pm (Female Hypertensive Patient).*

*I have stopped eating cassava, consuming sugary foods, and eating late at night so that I can recover rapidly. For instance, I take in a lot of vegetables in between meals; I make sure I don’t eat heavily after 4pm; and I take in less amount of salt (Male Diabetic Patient).*

4.7.6 Discussion of Coping Strategies

No matter the cause of biographical disturbance, Pranka (2015) shows that individuals with chronic conditions continue to interact with their social and institutional environments in a mutually constitutive relationship. Relying on family support and encouragement are the first strategies patients could adopt to live happily with chronic disease; this confirms the work of Holanda et al. (2016) that emotional coping mechanisms for the elderly with chronic diseases include family support. Elderly persons who are less isolated may have close family and friends who spend time taking care of them and their needs. Most participants reported receiving some form of support from their families through the purchasing of drugs, recreation, assistance in getting to the hospital, and/or financial support.

Social support is very necessary to overcome biographical disruption in that it influences the reconstruction of identity and well-being of the chronic disease patient. The study found that some participants had joined social support groups like church groups for spiritual, moral, and financial aid. These support groups, according to the study, provided
counselling and religious guidance to participants, and this gave them strength and hope to cope well with their chronic illness. The elderly persons use faith as a means of acceptance in times of hardship or challenge. In this regard, increasing the accessibility of support groups is important in averting the risk of an individual’s marginalisation.

Study participants also indicated that they have adhered strictly to the food and medication prescribed by their doctors and nurses, which has assisted them to cope with their chronic conditions. This is in concurrence with Folkman et al. (2012), who showed that older people figure out how to live with chronic diseases by managing them through mental methodologies that incorporate 'issue-centred coping' and 'emotion-centred coping.' Issue-centred coping includes endeavours to handle illness head-on by taking prescribed medication. Be that as it may, the research did not reveal emotion-centred coping strategies, as observed in studies by Folkman et al. (2012), and Cavannaugh et al. (2015), which say that emotion-centred coping includes managing one's emotions about the chronic disease by enabling the elderly persons to express outrage or disappointment about their condition. None of the study participants communicated outrage about their chronic conditions. On the contrary, those in the present study acknowledged their conditions and attempted their absolute best to adapt accordingly.

The study revealed that most of the study participants, especially the mobile ones, adopted social participation as one of their main strategies to cope with their chronic conditions by visiting their family members and friends. This is done in order to discuss problems and chat with them when they feel sad or neglected, which makes them become happy. Some even interact with their children, grandchildren and spouse. This supports the study by Weingarten (2012) which says that older persons with chronic diseases regularly live with chronic frustration and that mental outcomes of living with a chronic condition might be enhanced through exercises that incorporate social support. For instance, an elderly person
living with a chronic illness might be urged to have more critical associations with companions, mates and relatives.

4.8 Theoretical Relevance of the Study

The study reinforced the biographical disruption theory of Bury for the study of ageing and chronic disease in Akim Oda. The study supports the theoretical importance of Bury’s theory, as this framework guided the interview process and analysis to demonstrate how patients’ experiences of chronic diseases like diabetes, stroke, hypertension, and HIV/AIDS entangled body, social identity, family and social relations, and economic circumstance. Michael Bury's (1982) idea of biographical disruption was critical for the study of the experience of chronic diseases. The theory proposes, firstly that the experience of the illness adjusts one's concept of oneself and one's social world. Second, the logical system regularly used to comprehend regular daily existence is likewise influenced, which requires re-evaluating even subtle elements of everyday life. A third ramification is the preparation of resources in the changing conditions of chronic diseases. In agreement with Bury’s postulates, the present study shows how patients repair their biography and achieve a sense of normalcy through mobilization of cognitive and material practical assets.

The theory of biographical disruption provided a basis for explaining how older persons with chronic diseases responded to this disturbance and how they adapted to changing circumstances. The theory allowed the researcher to understand how the elderly living with chronic diseases managed the challenges they faced. The study additionally shed light on how chronic illnesses disturbed the body, social personality, family and social relationships, and the economic circumstance of elderly persons. The study employed this theory with the aim to understand the experiences of elderly persons living with chronic diseases and their coping strategies, such as trust in God, social interactions, adherence to
medications and prescribed diets, sleep, listening to music, and reading books and watching of television.
CHAPTER FIVE
SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of findings, conclusions and recommendations for improving the experiences of the elderly living with chronic diseases. It also provides reflections on the overall quality of health care at Akim Oda. Finally, it presents the implications of the study findings and identifies areas where further research is needed.

5.2 Summary of Findings

The study sought to explore the experiences of elderly patients living with chronic diseases and to investigate the issues relating to chronic diseases and ageing. It gave attention to both experts’ and elderly persons’ understanding of the causes of chronic diseases, challenges of living with chronic diseases, and coping strategies.

The study was conducted at Akim Oda in the Eastern region of Ghana. Qualitative data collection and analysis methods were used to achieve the objectives of the study. The study adopted the biographical disruption model by Bury (1982). The concept of biographical disruption describes how chronic illness in an individual’s life course threatens his or her self-identity.

While some participants were diagnosed with non-communicable disease, others were diagnosed with communicable disease. In finding solutions to their illness, participants reported to the hospital and others also resorted to ethno-medical care. Most of the participants had comorbid conditions. Most participants were also exposed to the risk of other non-communicable diseases when found to be living with a chronic disease like hypertension. Medical experts revealed how chronic non-communicable diseases such as diabetes, hypertension and stroke are diagnosed.
Study participants showed a high level of knowledge about the cause of their own chronic diseases. For this reason, participants were able to adhere to medication as a form of managing chronic disease. The underlying causes of non-communicable diseases such as diabetes, hypertension and stroke include diet, excessive alcohol consumption, physical inactivity, accidents, and emotional and psychological trauma. HIV was identified among the chronic conditions elderly faced in Akim Oda, but the afflicted study participants revealed that they have no knowledge about the causes of their diseases.

Challenges encountered by elderly persons living with chronic diseases include economic difficulties related to healthcare, such as cost of herbal and orthodox medication; transportation to hospital; social difficulties, such as neglect of patient by family or relatives, religious exploitation, sexual weakness, and inability to shoulder responsibility; delay in reporting to hospital; dementia; and physical challenges, such as loss of vision and inability to write. Chronic diseases create biographical disruption, not only for the patient, but also for family and caregivers, sometimes leading to neglect of patients when they lack social support.

Coping strategies identified in the study include material and symbolic support strategies and change in lifestyle behaviour. The ability of participants to join social support groups depended on the level of social networks available. Social support groups like the church provide opportunities for participants to meet counsellors to maintain psychosocial health. Participants used walking aids to compensate for the loss of vision and mobility.

5.3 Conclusions

The study identified communicable and non-communicable diseases as the categories of chronic diseases experienced by the study participants. HIV was the only communicable disease outlined, while non-communicable diseases were diabetes, stroke and hypertension. Therefore, HIV, diabetes, stroke, and hypertension are the most prevalent diseases among the
elderly in the Akim Oda Government Hospital. In addition, the frail nature of the elderly with chronic diseases indicated that there is an interplay of biological, psychological and social changes that is associated with chronic disease and ageing.

The study also revealed unhealthy diet, physical inactivity, hypertension, alcohol abuse, excessive smoking, and psychological distress as the factors that add to the development of chronic diseases among the elderly in the study region from both elderly people's and specialists' points of view. This suggests that putting resources into wellbeing throughout the life course will help to ensure that a decent number of individuals reach old age in good health. This should include expanding NHIS and LEAP, as well as diversifying healthcare provision to place greater emphasis on preventive, mental health, and general wellness care.

Bury's (1982) concept of "biographical disturbance" has been a main framework for this study on ageing and chronic diseases in Akim Oda. The idea suggests, first, that a man's stock of learning of self and social world is disturbed by the experience of chronic disease. Second, it proposes that the ordinary explanatory models developed throughout life are thrown into question, requiring a re-examining of biographical particulars. The study has shown that chronic diseases such as HIV, diabetes, stroke and hypertension disrupt the physical, social and emotional life of the elderly to an extent that an elderly has to adopt and develop a new identity altogether. For example, most of the elderly persons were unable to walk and interact with their family and friends. Many lost their jobs and/or went into bankruptcy, because of the disruption caused by the chronic conditions they suffered from. A third implication of the biographical disruption theory is the mobilization of assets to withstand major changes to life conditions under chronic disease. Organisation of intellectual, material and practical assets to repair the biography and keep up regular day to day activities is the adaptive reaction to the interruption. The findings of the study uncovered that when the
study participants encounter the challenges with the disruption, they adopted several coping strategies in order to survive. These include reliance on God, watching television, family support, social support, adherence to prescribed food and medication, rest, and physical activities like jogging and aerobics at the gym.

5.4 Recommendations

This section contains recommendations from the study for health workers, elderly chronic disease patients, and Ministry of Health officials. Recommendations are for improving the conditions and experiences of the elderly living with chronic diseases, aiming eventually to increase the quality of health care at Akim Oda.

5.4.1 Health Workers

1. Hospital authorities should provide physical space for indoor games for patients working to regain mobility and physical control, staffed by health workers. Expansions to the existing physiotherapy department would also allow it to accommodate more patients.

2. Smart health care delivery is expected of nurses and other supporting staff to enable timely and early delivery of services to patients to reduce waiting time, especially relatives of patients who need to go to work.

5.4.2 Patients

1. The elderly living with chronic disease/s ought to continuously respond to scheduled reviews of the health facilities without fail.

2. Patients need to obey all medical instructions and adhere to prescribed food by their doctors.

5.4.3 Ministry of Health

1. The Ministry of health should embark upon intensive public education on chronic non-communicable diseases.
2. The Ministry should educate health workers to encourage social support in the form of family and support groups.

3. The Ministry should facilitate the formation of chronic disease clubs and organizations with health workers acting as facilitators at the national, regional and district levels to create awareness of chronic diseases.

4. Provision of all standard chronic disease treatments should be covered under the National Health Insurance Scheme.

5. The Ministry should collaborate with herbal medicine practitioners to prescribe medicine that will facilitate effective recovery and train these herbal practitioners to be able to deliver their work without any serious repercussions to their patient.

5.5 Implication for Social Work Practice

Social workers as brokers can link elderly persons living with chronic diseases in our communities to existing support programmes such as Livelihood Empowerment against Poverty (LEAP) and National Health Insurance Scheme (NHIS). Some of the elderly persons living with chronic diseases are illiterate and unaware of existing programmes aimed at supporting the elderly. Social workers should educate family members and the public to make efforts in keeping healthy family ties and also encourage them to maintain cordial relationships with their relatives who are suffering from any form of chronic diseases. Social work educators must sensitize and teach people about chronic diseases and their effects on the elderly. The education should be sustainable and be directed more at hospitals and homes of elderly persons experiencing chronic diseases. Social specialists must be learned about policies, legislations, and social projects that influence older persons. In addition, they must be knowledgeable about the ageing process, problems elderly persons suffering from chronic diseases are likely to face, and the necessary steps to take. This will enable them to address old age-related problems, such as chronic diseases, well.
Research by social workers on elderly persons living with chronic diseases will enable social workers to survey the necessities and assets of elderly individuals in their condition and assess the viability of social work services. It is additionally fundamental for social workers to comprehend the effect of social policy and legislation on elderly persons in the community.

5.6 Implications for Future Research

Findings from this study provide initial exploratory results that give opportunities for further research. Firstly, the research was conducted using only in-depth interviews (purely qualitative approach). A mixed research methodology would give a wider perspective to the experiences of patients living with chronic diseases and explore the representativeness and generalizability of the findings from Akim Oda. Secondly, a study of a more heterogeneous and larger geographical area will improve the generalizability of the findings and bolster the potential influence on policy direction.

5.7 Conclusion

This study concludes that there are different biographical disruption experiences among participants in the study area, with impacts on their lives that influence the kinds of adaptive strategies suitable to improve deteriorating health and social and economic status. Similar to the observed coping strategy by most studies, family support was a common adaptation strategy among participants in the study area. As demonstrated by the responses from study participants, coping with the challenges of chronic disease requires intensive interaction between patients and their families to find the best ways of working together. The participants largely perceived that poor eating habits, excessive smoking, physical inactivity, excessive thinking or worries were associated with increased risk for diabetes, hypertension, and stroke which could consequently lead to deformity or death.
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