

**UNIVERSITY OF GHANA**  
**CENTRE FOR SOCIAL POLICY STUDIES**

**IMPLICATIONS OF HEALTH CHALLENGES OF THE AGED ON  
HOUSEHOLD WELLBEING IN ADENTAN MUNICIPALITY**



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## DECLARATION

I **KAFUI YAWA RANDOLPH**, the author of this thesis, do hereby declare that except for references to other people's work which I have duly acknowledged, the study herein presented is the first of its kind to be carried out in the Department of Centre for Social Policy Studies, University of Ghana, Legon, during the 2014/2015 academic year under the objective supervision of **PROF BRIGID M. SACKEY**. This work has never been submitted in any form, whole, or part for a degree in this University or elsewhere.

.....

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**PROF BRIGID M. SACKEY**

**DATE**



## DEDICATION

This work is dedicated to my Husband, Emma, and my children; Papa, Naa and Susu.

It is also dedicated to my extended family and to all readers and above all, to all aged in Ghana with loads of love!

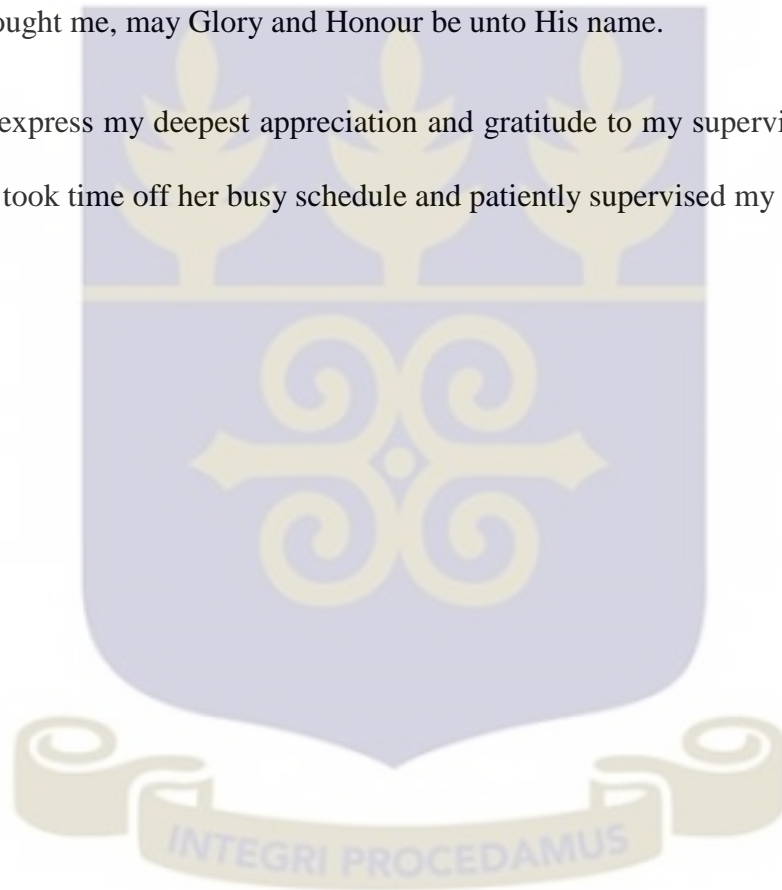


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My heartfelt gratitude goes to the Lord God Almighty for the strength, wisdom and direction he gave me through the journey of my life and the completion of this work. This is how far the Lord has brought me, may Glory and Honour be unto His name.

I would like to express my deepest appreciation and gratitude to my supervisor, Prof. Brigid M. Sackey who took time off her busy schedule and patiently supervised my work



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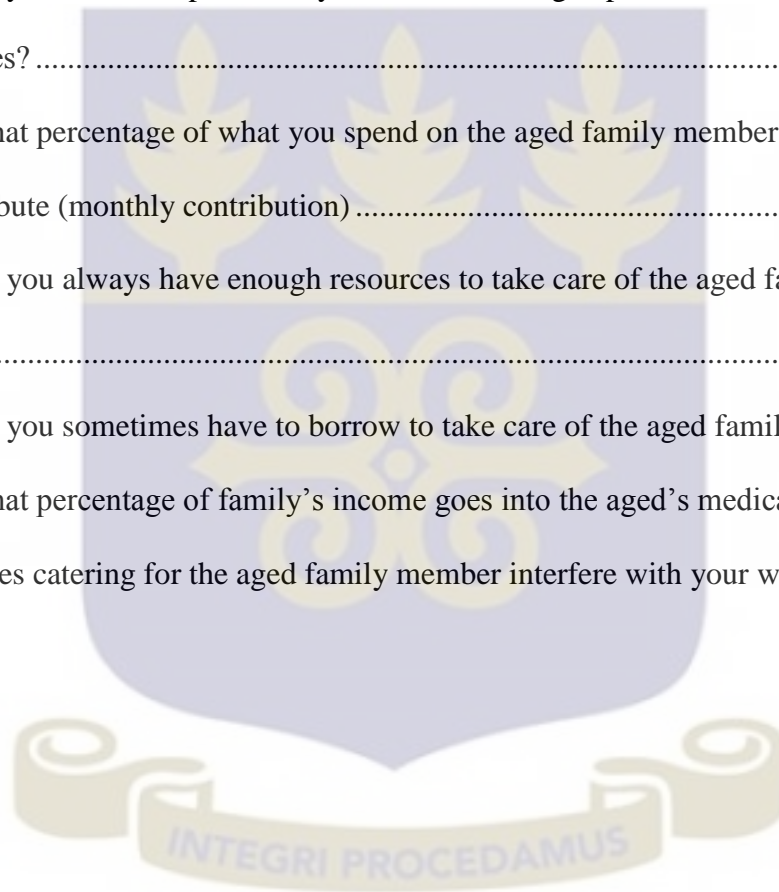
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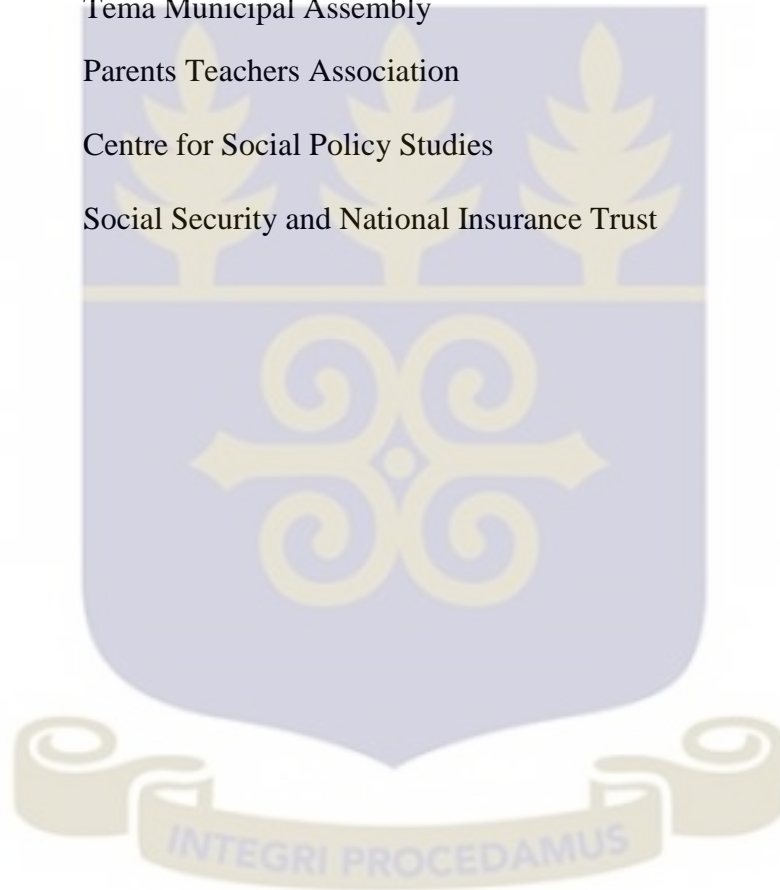
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## LIST OF ACRONYMS

Below are the definitions of terms used in the study:

<b>WHO</b>	-	World Health Organization
<b>NHIS</b>	-	National Health Insurance Scheme
<b>GSS</b>	-	Ghana Statistical Service
<b>SSNIT</b>	-	Social Security and National Insurance Trust
<b>SMC</b>	-	School Management Committee
<b>TMA</b>	-	Tema Municipal Assembly
<b>PTA</b>	-	Parents Teachers Association
<b>CSPS</b>	-	Centre for Social Policy Studies
<b>SSNIT</b>	-	Social Security and National Insurance Trust



## ABSTRACT

The cross-sectional survey investigated the implications of health challenges of the aged on household's wellbeing in the Adentan Municipality. It specifically sought to ascertain the effect of health challenges of the aged on their households' finances, household's social life and on the health of caregivers. A sample of 80 caregivers and the aged family members they care for were selected from Adentan and Amrahia to constitute the sample for the study. The analysis took a descriptive form which revealed that the finances of households with aged who have health challenges are over stretched. This is attributed to lack of contribution from other family members and medical care of the aged among others. Caregivers do not have the best of social life as result of assuming responsibility of taking care of the aged family members since their worship lives; entertainment and fellowship with friends have been affected on assuming the responsibility of caring for their aged family members with health challenges. Majority of caregivers describe their health status as poorer since assuming the responsibility of caring for the aged family members with health challenges which can be attributed the emotional stress they undergo most of the time and the demanding nature of the caregiving. It is recommended that family care givers for the aged be given some form of formal training. Institutions to train individuals in gerontological services should be established to help families in need of such services.

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background of the Study

Ageing has become a global phenomenon and indeed a critical policy issue receiving some recognition by governments of both developed and developing countries (Okoye, 2014). Globally, there seemed to be a dramatic increase in aging population with greater numbers occurring in the developed and developing countries. According to the World Health Organization, (WHO) between 2000 and 2050, the proportion of the world's population over 60 years of age will double from about 11% to 22%. The absolute number of people aged 60 and over is expected to increase from 605 million to 2 billion over the same period (WHO, 2014). The number of older people (65+) across the globe is expected to more than triple by 2100, increasing from 784 million in 2011 to 2 billion in 2050 and 2.8 billion in 2100. The more developed regions of the world have been leading the process of ageing and, by 2050, the proportion of older people in these regions is expected to be double that of children under 15 years 31.9 and 16.3% respectively (World Population Prospects, 2011).

Following this trend, populations in developing countries will also be aging rapidly in the coming decades. The number of older people in less-developed countries is expected to increase from 249 million in the year 2000 to 690 million in the year 2030 (WHO, 2014). Furthermore studies have found that older adults, persons aged 65 or older, are growing in number faster than any other age group both nationally and internationally. For instance, in 2011, there were 41.4 million older adults in the United States. This means that one in eight people was an older adult (Administration on Ageing, 2012). Globally by 2015, it is expected there will be more people over age 65 than young people aged 15 and younger (United Nations Population Fund & Help Age International, 2012). This transformative demographic

shift presents numerous challenges as aging comes with its attendant health challenges. In general, it is established that the elderly have greater susceptibility to diseases and they simply get frailer as they age (Economist Intelligence Unit, 2009).

As a result of this demographic change, it is also predicted that the prevalence of chronic diseases, and health care needs and utilization will increase substantially among this aged population (Nie JX, Wang L, Tracy CS, Moineddin R, Upshur RE, 2008, 2010). According to Mba, (2006) it is apparent that older women in urban Ghana are assuming a double burden of disease. They are afflicted with the usual tropical diseases such as malaria and other vector-borne illnesses, and they are now experiencing chronic illnesses such as hypertension and diabetes. Empirical evidence from the Ghana Statistical Service (2002) suggests that Ghana's ageing population has more than tripled in about 30 years (1984-2000). Unfortunately, this has occurred without a corresponding social care for the aged (Mba,2004b). In spite of the demographic shift, older persons' concerns have remained marginal to the major social and economic debates in the country. As a result, many older people, particularly women, are faced with inadequate healthcare, poor shelter, isolation and inadequate and insecure income. Medical expenditures on the aged which are mostly borne by families and relatives are therefore expected to increase (Meijer Cde, Wouterse B, Polder J, Koopmanschap M 2013).

Ageing may be defined as a continuous process of progressive change in all the structures and functions of the body of an individual (Cox & Mberia, 2007). Some factors that are associated with the phenomenon are the drop in the person's activity level, social attitude and social roles. All over the world, most especially in Africa, care giving for elderly persons is generally the responsibility of their families (Grootegoed, Knijn & Da Roit, 2010). It is a custom among Ghanaians that caring for the aged (parents) is a responsibility of the family

both nuclear and extended. In the United States of America also, Curry et al (2006) report that family caregivers provide an estimated 80 percent of care for older adults.

According to the Institute of Medicine Report (2009), “Family members, friends, and other unpaid caregivers provide the backbone for much of the care that is received by older adults in the United States”. For the year, 2007 an estimated \$375 billion was spent on caring for the elderly (National Alliance for Caregiving 2012). Many family caregivers support the elderly patients at significant cost to their own physical, emotional, and financial well-being (National Alliance for Caregiving, 2012). An estimated 44 million Americans aged 18 and above provide unpaid assistance and support to older people and adults with different forms of sicknesses and disabilities who live in the community. Care is provided to someone who is elderly and ill by 65.7 million caregivers who make up 29% of the US population (National Alliance for Caregiving, 2012).

The value of unpaid family caregivers will likely continue to be the largest source of long-term care services in the US, and the aging populations (65+) will more than double from 2000 to 2030, increasing to 71.5 million from 35.1 million in 2000 (Coughlin, 2010). Though informal caregiving by family members and relatives is often inherently rewarding for those who provide it, it can also be emotionally, physically, and financially burdensome (Chorn-Dunham & Dietz, 2003). Most often, caregivers spend a substantial amount of time interacting with their care recipients, while providing care in a wide range of activities. In the case of elderly persons with chronic disabilities like osteoporosis, Parkinson’s disease, dementia, rheumatoid arthritis, depression etc., informal care giving can be expensive in depending on the severity of the condition. For example, caring for the aged places physical, social, financial and psychological strains on their families/caregivers. (Goldzweig, Merins, ganon, Peretz, Altman & Baider, 2013).

In the developing countries such as Ghana, there is not much information on the contribution of families to the care of the aged as empirical studies are inadequate. The present study therefore examines the effect of health challenges of the aged on the wellbeing of their households. Households according to the Ghana demographic survey (2014) comprises parents, children, and extended family members who do and share things together.

## **1.2 Problem Statement**

Ageing with its associated health issues and challenges on household welfare of the aged are of much concern to citizens and governments of different countries all over the world (Ageing Well, 2012). This is because health challenges of the aged impact negatively on their families in a country like Ghana which does not have pragmatic social intervention programmes to support the elderly. Even though The National Health Insurance (NHIS) covers the aged, some age groups are excluded. People within the age 60-69 are not covered by free health care. Also, the NHIS treatment does not cover the chronic, non-communicable diseases, such as stroke, cancer and diabetes, which predominate. As a result health challenges of the aged impact negatively on their households. This happens because the health care cost in addition to the cost of providing other needs becomes the sole responsibility of the family.

In Africa it is estimated that by the end of 2014, the population of the aged will increase to 1.6 billion. According to Apt (2014), it is noted that Africa's ageing population is faced with changing dynamics and growing adequacy of customary care and family support, poverty and material deprivation and ill-health marginalization from health care service personnel. In Ghana, increasing unemployment which implies that there will be more aged with health challenges with more of their families earning less or even nothing. The present study

therefore attempts to investigate the effect of health challenges of the aged on household wellbeing the Adentan Municipality as a case study.

Life expectancy is 56 years in Ghana and about 40% of the population under 70 are inactive (National Population Census, 2010). Another concern is that the national pension policy covers only the formal sector employees. Meanwhile a lot of the aged or the population who ages even up to 70 and more are working in the informal sector. The question therefore is, if they have health problems after retiring what happens to them? In short, most social policies in Ghana do not favor the aged and these exclude them from society.

### **1.3 Objective of the Study**

The aim of the study is to investigate the effect of health challenges of the aged on their household's wellbeing. Specifically the study seeks to:

- ascertain the effect of health challenges of the aged on their households' finances/economic stability
- determine the effect of health challenges of the aged on their household's social life.
- determine the of health challenges of the aged on the health of the household care givers

### **1.4 Research Questions**

The questions that are worth investigating in the current study on the effects of the health challenges of the aged on household wellbeing are stated as follows:

- How do health challenges of the aged affect the families' finances/economic stability?

- How does caring for the elderly affect the social life of their family?
- What is the effect of caregiving on the health of the household care givers?

### **1.5 Significance of the Study**

Even though the National Ageing Policy was put in place July 2010 to take care of the welfare of the elderly, the policy still remains on the shells or yet to be implemented. It is probably because the challenges of the aged that appears to affect their welfare are not known or have not been brought to the public light. This study will therefore motivate the state for the smooth implementation of the policy.

Many empirical studies have been conducted in Ghana but most of these studies did not look at the health challenges of the aged and their effect on the household's wellbeing. The dissertation will bring to light the health challenges of the aged and its implication on household's wellbeing.

Though the study seeks to add to the existing literature on the wellbeing of household in Ghana, it also seeks to bring to light the huge cost of treating some of the disease burdens the aged suffer. Though the National Health Insurance scheme is there to cater for the health needs of the aged, cost and treatment of terminal cases are not taken care of by the scheme hence family and children of such elderly are forced to bear the cost of treatment. This in turn affects the families' income, their social life and their general wellbeing

Furthermore, the study intends to help in the formulation of new policies or review of the existing policies and interventions strategies for the aged in Ghana. Aside from throwing light on the overall health conditions among elderly population, and inform policy on caregiving, the study also aims at contributing to knowledge and raising awareness about the plights of the older population in Ghana and other parts of Africa. The study will awaken

the public on the need to relook at the health care for the aged which excludes elderly population between the ages of 60 – 69 years.

### **1.6 Definition of household/ family**

A family is defined as a group of individuals related to each other by blood or adoption. A household synonymously comprises families possibly of different generation (Edmonds 2004). In Africa and Ghana for that matter there are three generational households, which comprise grandparents, parents and children with other siblings (Department of Social Development, 2002a). Changes in household composition, with a larger number of children, especially those aged 0–6, migrating into pensioner households (Edmonds 2004). Case and Deaton (2001), estimate that 60 percent of all African households are three-generational households with children.

### **1.7 Limitations of the Study**

Accessibility to households to solicit data on this topic itself was challenging as many families generally did not want to disclose information about the health status and problems of their family members to strangers. Another limitation was the unavailability of some of the primary caregivers (those who are financially responsible for the upkeep of the elderly) to grant interviews on economic pressures of caregiving of the aged (is also seen as a challenge). This is because some live outside Adentan where most of them work. Some are also resident abroad but send regular remittances.

### **1.8 Organization of the Study**

This work is presented in five chapters. The first chapter deals with the background to the study, problem statement, objectives of the study, organization of the study. Chapter two

deals with review of relevant literature and theoretical framework. Chapter three deals with methodology. It consists of the study area, research design, population, sample size, sampling techniques, research instrument for data collection and data analysis. Chapter four concentrates on presentation and analysis of data and discussion of findings. While chapter five deals with summary, conclusion and recommendations.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

The chapter deals with the theoretical orientation of the study followed by a review of literature on the subject of caring for aged, implications of their health challenges on family wellbeing; economic stability, social life and health.

#### **2.2 Theoretical Framework**

The study is underpinned by modernization theory on aging. Even though it is important for a country to gain some development, modernization has created some form of imbalances in the care of the aged which can be identified through four key areas. The theory is predicated on the effects of technological advancement, industrialization, urbanization and the spread of modern education (Berquo & Xenos, 1992; Treas and Logue, 1986; Cowgill, 1974, 1986; Goode, 1963 cited in Mba, 2006). The theory posits that the development of health technology raises longevity, which in turn results in prolonged retirement of the older population that is often accompanied by a noticeable loss of income and social prestige.

Also, industrialization requires a separation of work from home and a highly mobile work force, which weakens familial ties to a particular geographical location. Increasing technology means the younger ones take over thus reversing the roles hitherto played by the aged where skills and knowledge acquired by the relatives make them not to depend on the extended family and aged which hitherto was the case in the past. This pushes the old to retire and make them dependent on the family thereby losing their social status and respect.

Similarly, modern education leads to changes in values and intellectual development across generations as younger people place greater emphasis on self-fulfillment as individuals rather

than on their responsibilities toward their relatives. It can, therefore, be argued that modernization renders living in extended family households less essential and economically less viable and therefore facilitates the transition to conjugal or nuclear family living arrangements.

The phenomenon of urbanization under the modernization theory (Burgess, 1960; Cowgill, 1974, Cowgill & Holmes, 1972 cited in Aboderin, 2004) contributes to the weakening of traditional extended family and filial obligation values as the main causes of declines in support to older kin. On one hand, customary filial obligation norms per se are weakened by the rising influence of Western values of individualism and secularism and an emphasis on the emotional bonds within the nuclear family. On the other hand, conformity with such obligations is weakened by the demise of the extended family and the concomitant loss of older people's status and roles. This erodes their former powers to enforce children's conformity with filial duties such as financial support, land acquisition, advice on marriage and their resources to offer to their children in exchange for support as well as social security for both children and the aged.

As a result, support is no longer compelled by the force of custom or household members but depends increasingly on young people's discretion and sentiments toward their older kin. Ultimately, the decline in old age family support is seen as being underpinned by an increasing unwillingness of the young to provide for the old. Modernization theory on ageing has provided the main platform for the debate on changes in family support for older people in both the industrialized and the developing worlds.

Although its well-known proposition of an 'abandonment' of older people in individualistic society, the modernization model continues to be the principal and most common framework for explaining the decline in familial material support for older people most especially in the

developing countries. Many have now lost respect, protection and now have been subjected to the risk of isolation and insecurity.

According to the theory, the more modernized a society becomes, the more the status of older people declines and caregiving has been left in the hands of just the household.

When applied to aging, modernization theory has much to say about the effects of modern society, specifically industrialization, on the quality of life for many older individuals. For example, the shift from preindustrial to industrial society automated many jobs previously performed by elders, changed the skills required for success in many careers, and necessitated higher education to acquire these skills. As a result, many elders have been marginalized and reduced in socioeconomic status. Further, because of industrialization, there has been a trend toward urbanization and a shift from extended families to nuclear ones. There has been a concurrent shift in the locus of authority from family elders to government officials, further marginalizing and decreasing the status of many elders as well as changing their source of support.

In preindustrial societies, neighbors were widely dispersed, not particularly well-educated (with the highest level of education often a high school diploma), and focused on rural farming. In contrast, modern societies tend to be urban, literate, and industrial. In urban communities, there typically are sophisticated transportation systems (e.g. bus systems). Families are usually nuclear in nature (e.g., a married couple and their unmarried children vs. the extended family of grandparents, parents, and children). Because of such characteristics of an urban society, the source of authority tends to shift from the elder in the home (because frequently there is no elder in the home) to the government or other official source.

To this end it is expected that the present study on the care and upkeep of the aged with health challenges is likely to be the sole responsibility of only the close relations. This puts a

strain on the family's economic resources and also has implications for the health and social life of the caregivers.

## **2.3 Review of Related Studies**

### **2.3.1 Psychological Effects of Caring for the Aged with Health Challenges**

In a recent study by Goldzweig, G., Merims, S., Ganon, R., Peretz, T., Altman, A. & Baider, L. (2013) psychological distress, social support, and coping strategies reported by partners who were family caregivers to older patients with cancer were compared with those reported by a control group of similarly aged people whose partners were not suffering from life-threatening illness. The results describe relevant implications for caregivers for older cancer patients. Among the research group of caregivers, levels of psychological distress were almost double in comparison to the healthy control group. Caregivers reported lower levels of social support and low levels of coping behaviours which correlated negatively to distress. Increased ages of patients accentuated caregivers' distress.

According to Goldzweig et al. (2013), Psychological distress of caregivers to cancer patients aged 71+ was four times higher than that of the control group, while they reported half of the coping behaviours reported by the control group. The higher distress levels found in caregivers for older patients could be due to a more realistic sense of inevitable separation and grief. (Hsu, et al, 2012) Possibly, caregivers have to deal with feelings of hopelessness and helplessness about their own future as well. Caregivers to older patients (71+) reported lower levels of support from their spouse (the patient) in comparison to caregivers to younger patients (60–70 years). Caregivers for older patients with cancer may experience a continuous process of disengagement resulting in a reduction in social involvement. The emotional support the patient could supply is either diminished or absent, leaving the caregiver with an unfulfilled expectation of support and emotional care. (Hsu, et al, 2012)

The single salient explanation that can be drawn from this overview is that care giving is not an episodic or closely bound feature of people's lives but it is a long-term commitment of which the conditions that caregivers face, and the transitions through which they must pass are in a state of kaleidoscopic change. According to Woo et al (2010), Characteristics of caregiver stressors, cultural norms concerning care giving, and informal and formal support in different cultures may have a huge impact on caregiver vulnerability and/or resilience. To better understand and ameliorate care giving stress and focus on evidence-based policies, there is a great need for studies describing appraisals provided by caregivers' from different cultures about caring for an aged partner diagnosed with an ailment.

Specifically, there is a need for studies comparing cultures where most of the care is provided at home by close family members, to cultures where most of the care is provided by professional caregivers outside the patient's home (Smith et al., 2009). Studies consistently report higher levels of depressive symptoms and severe fatigue among caregivers of the sick elderly than among their non-care giving peers (Pinquart and Sorenson, 2003). Most family caregivers of older people are themselves elderly. The average age of those caring for someone aged 65+ is sixty-three, with one third of these caregivers in fair to poor health (Mack, 2005).

There is cumulative consistent evidence that informal caregivers for elderly cancer patients experience high rates of anxiety and depression, with 20–30% of all caregivers believed to be at high risk for psychiatric morbidity. Estimates show that between 40 and 70% of caregivers have clinically significant symptoms of depression, with approximately one quarter to one half of these caregivers meeting the diagnostic criteria for major depression (National Alliance for Caregiving (NAC) & AARP, 2008, 2009). In addition, both caregiver depression and perceived burden increase as the care receiver's functional status declines. Family

caregivers describe feeling frustrated, angry, drained, guilty, or helpless as a result of providing intense care. Some 16% feel emotionally strained and 26% say that caring for the patient is hard on them emotionally. An additional 13% of caregivers feel frustrated when there is little or no improvement in the condition of the care recipient (Center on Aging Society, 2009).

Caregiving may also result in loss of self-identity, lower levels of self-esteem, constant anxiety, or feelings of uncertainty, less self-acceptance, and a sense of being ineffective or lacking control (Buhr et al., 2008). Furthermore, evidence shows that most caregivers are ill prepared for their role and provide care with little or no support, yet despite this, and the fact that they suffer from poor health themselves, more than one-third continues to provide intense care. It also emerges that an influential factor in a family caregiver's decision to place a terminally ill relative in a long-term care facility is the state of his or her own physical health (Navaie-Waliser et al., 2004).

A review of the literature tells us that caregivers can have significant psychological and psychosocial problems (Gan & Schuller, 2002). Caregivers experience twice the depression rate of the general population and depression is greatest for those taking care of cognitively impaired relatives (Crawford & Unger, 2004). It is also argued that depression and loneliness due to people having lost their social networks persist for years after the death of a care receiver (Larkin, 2001). Nelms et al. (2003), in an Australian study, found that anxiety and depression in families is higher among those who care for an injured (traumatic brain injury, or TBI) relative and that cognitive, behavioural and emotional changes are the strongest predictors of anxiety and depression. They conclude that, "Every attempt should be made to develop models of long-term support and care that alleviate these sources of burden on relatives" (p.453).

There is ample evidence that women in general report more psychological distress than men. This is commonly related to gender socialization and to differentiation of roles. It is known that women report more emotional distress in a variety of situations, not just caregiving (Miller, 1990). This is ascribed to the fact that women are seen to have stronger affiliative orientations; they are perceived as more sensitive in relationships and more likely to use social support groups.

### **2.3.2 Caring for the Aged with Health Challenges and its Effect on Families Economy**

Reinhard et al (2008) noted that on the average, four out of ten caregivers spend five or more years providing support, and two out of ten have spent a decade or more of their lives caring for their family member. This is a day-in, day-out responsibility. More than half of family caregivers provide eight hours of care or more every week, and one in five provides more than forty hours per week (Reinhard et al, 2008). Care giving imposes considerable direct financial and economic costs on caregivers and their families such as medical services, medical devices, drugs, food, clothing, and personal items for the elderly.

Also many caregivers in the workforce have to deal with such issues as lost wages, job security, career paths and employment benefits such as health insurance and retirement savings and so on (Chorn-Dunham and Dietz, 2003). This is because due to their care giving (depending on the intensity) they may have to do the following; make changes in the workplace, arriving late, leaving early or taking time off, taking a leave of absence, dropping back to part time, giving up work entirely and sometimes turning down promotions (Nixon, 2008). All these can lead to lost wages among other things. For example, and the like. Also because care giving may conflict with caregivers' employment potential, it may generate productivity losses for the economy as a whole.

According to LeRoux (2006) both men and women report lost opportunities for promotion and career advancement, but the gendered nature of care, especially in the case of the elderly population, has important financial implications. Employed women provide as much care as the unemployed. Taking care of a family member has career and financial implications for those in the paid labor market. Female caregivers find themselves in a complex bind: Women as a group are at a financial disadvantage. The burden of care is shifted to family (still, by and large, the domain of women) under the assumption that they are willing and available to provide care (LeRoux, 2006).

### **2.3.3 Social and Health Effects in Caring for the Aged with Health Challenges**

According to Friedland and Lewis (2004) the physical, emotional and social burdens attached to providing care to a frail elderly person can exact a heavy toll on family caregivers, including loss of leisure, increased stress and impaired physical and psychological health. Mack (2005) reports that prolonged caregiving has negative effects on the emotional and physical health of the caregivers. Talley and Crews (2007) in a study, report that compared to non-caregivers, caregivers experience one or more chronic health conditions at nearly twice the rate, 45 percent vs. 24 percent.

Many researchers such as Chappell and Reid, (2002) and Pearlin, Pioli, and McLaughlin, (2001) have examined the burden and quality of life issues associated with care giving. For example, the more informal hours a caregiver works, the greater the burden she or he experiences. Caregivers may sometimes experience emotional strain if they worry about the elderly person's safety and security while they are at work (Chappell & Reid, 2002). Family caregivers can be negatively affected by the care they give. The effect can be social and psychological, such as taking unpaid leaves from their jobs, reducing work hours, rearranging their schedules, and restricting their social contacts (Stoltz, Uden & Willman, 2004). This

invariably will affect the quality of care and may even result in depression, reduced morale and in some cases result in elder abuse and neglect. The care giver as well as the elderly person can be the abuser in these situations. Given such consequences, it may be better to get the caregiver to stop formal work completely and concentrate on caring for the elderly person.

However the question is, how will the caregiver be provided for? Gender differences are especially important in who becomes a caregiver. Studies have reported that most caregivers are women who handle time-consuming and difficult tasks like personal care (Long & Harris, 2000; Brewer, 2001; Dettinger & Clarkberg, 2002). The average caregiver according to Silverstein and Parrott (2001) is generally a woman in her 40s who is caring for her older parents. According to them, the prevalence of care giving among adult women is high when examined as a lifetime risk. Among women 45-49 who have a surviving parent, more than half can expect to experience parental care giving at some point in their lives (Silverstein & Parrott (2001).

The caregiving role has become a normative or expected part of the life course of women. Spillman and Pezzin (2000) however report that men are also becoming involved in care giving. Male caregivers are becoming more involved in complex tasks like managing finances and arranging care, as well as direct assistance with more personal care (Nie et al, 2008). Although care giving for elderly persons has increasingly become a normative life event, there is little government support available in Nigeria to aid family caregivers in their efforts. The underlying assumption probably among policy makers is that it is not necessary to pay for care that families already provide for free.

According to Silverstein and Parrott (2001) a related fear among policymakers all over the world is that if the government were to assist families in their elder care responsibilities by

providing financial incentives for caregivers, then family members would substitute this paid, formal care for the informal care they had been providing that formal services would crowd out informal ones if the former were readily available. Although it has often been argued that paying family members to provide care requires an examination of some fundamental assumptions about care and work, critics of paying for family care have voiced a range of concerns about how this practice might undermine social values. They suggest that in this and other ways payment would decrease the quality of the caregiving experience for care recipient and caregiver, with paid services substituting for unpaid care now provided. It is often asked, what is the difference between work people do for love and the work people do for money? What does society expects and requires families to do for love without expectation for money?

The answers to these questions are not very easy to come by but studies have shown that various social and economic pressures are reducing the amount of unpaid (informal) care families are able and willing to provide to older persons (Benjamin et al, 2008). Other studies have also shown that the wellbeing of caregivers can be greatly affected if they receive some financial incentive that may enable them to stop wage employment partially or fully and devote all their time and energy to caring for the elderly persons (Schwartz, 2002; Foster et al, 2003).

According to (Jacobs, 2000, p. 84) advice for caregivers spoon-feeding, toileting and comforting can cause caregivers to lose heart, burn out and break down. Once that occurs, their ability to care for their loved ones is undermined. Sheer exhaustion of energy and spirit may also place caregivers at risk for developing health problems of their own” Care giving seems to be detrimental to the health of caregivers. Larkin (2001) reports that the overwhelming majority of caregivers neglect their medical and other needs, both during care

giving and after their relative dies, suggesting that intervention is needed to ensure that caregivers access services and take care of themselves.

Suthers (2006) reported that caregivers are more likely to have high blood pressure, elevated insulin levels, weak immune systems and cardiovascular disease. Of caregivers over 65, 63% have a greater mortality risk than their non-caregiving peers. Miller (1990) found a small but statistically significant difference in health strain between husbands and wives providing care giving, with wives experiencing more strain. Thus it is accepted that care giving can negatively impact the health of caregivers. This is typically framed within a financial context (as seems to be the focus of discussion around health care), and from the perspective of the needs of the person being cared for (if the caregiver is not healthy, she cannot provide good care). Yet, physical health is only one part of the picture since mental health is also at stake (LeRoux, 2006).

#### **2.3.4 Role Demands and Burden of care Giving**

The time involved in care of the disabled varies across the spectrum. Care giving can involve daily care and interaction, or it can mean advocacy for medical services on behalf of a relative. Estimates are that care giving activities add about an extra work week to women's monthly load (Gerstel & McGonagle, 2002). It is known that 17% of caregivers provide 40 hours of care a week or more (National Family Caregivers Association, 2007). But it is also know that role expectations are increasing. The concept 'caregiver burden' which is frequently used in the literature, is a slightly different way of describing role demands. Many researchers have looked at stress and burden experienced by caregivers (Degeneffe, 2001; Erghet al., 2003; Gan & Schuller, 2002). In summary, the caregiver role is consistently described and shown to be a demanding role, which does not lighten over time. Although a variety of factors can impact the experience of caregiver burden, it is repeatedly shown that

caregiver needs and social support play an important role. Remarkably, this discussion is not contextualized in terms of the gendered nature of the role (LeRoux, 2006).

### **2.3.5 Social policy on the aged in Ghana**

According to Mba (2006) governments of Ghana have shown some concern for the aged. For instance, July 1, Ghana's Republic Day has also been declared as Senior Citizens Day, which is one way of responding positively to the concerns of the elderly and a clear indication of national commitment to the wellbeing of the aged. Similarly, the revised national population policy stipulates, inter alia, that "deliberate measures shall be taken to alleviate the special problems of the aged and persons with disabilities with regard to low incomes and unemployment" (Republic of Ghana, 1994: 39).

The government of Ghana has also put in place a new National Health Insurance Scheme (NHIS) under which some exemption benefits for the aged that will take into account their vulnerability and special circumstances will be provided (Daily Graphic, 2003). The scheme is expected to go a long way toward defraying the medical bills of the elderly sick. However the cut-off point for the qualification under the proposed NHIS scheme for the aged is 70 years while the official retirement age in the country is 60 years. In the same vein, efforts to address issues impacting negatively on older people through a National Ageing Policy are underway.

The government further supports various non-governmental organizations working for the aged. These organizations, which include Help Age Ghana and Christian Action on Ageing in Africa have been very instrumental in bringing to the fore the problems that confront the aged in our society, and helping to create national awareness about the responsibility of the young toward the welfare of the elderly. But these organizations are few and operate very few old-age institutions (old people's homes).

It is found that in Nigeria, policies geared towards providing care for elderly persons are almost non-existent (Okoye, 2012). The only Federal policy for the elderly is the Pension Scheme which incidentally is only for elderly persons who worked in the civil service. The majority of elderly persons who were self-employed are without any form of financial support from government except the ones they get from their families and friends. Okoye (2012) is therefore proposing a financial incentive programme from NGOs and governments for family members who are caring for elderly persons.

### **2.3.6 Incentives Programmes for Elderly Care Givers in Different Parts of the World**

Various financial compensation programmes have been developed around the world supporting (informal) caregivers. Nixon (2008) reported that there is a refundable elderly caregiver tax credit programme. This is a programme where cash payment is given to caregivers, in the form of a \$1000 credit towards the caregiver's state income tax, regardless of actual expenses. Because the tax credit is proposed to be refundable, caregivers with no state income tax obligation would still receive a "refund" check from the state treasury amounting to \$1000. According to Nixon (2008), this programme targets caregivers caring for an older adult who are 60 years old and above.

In other parts of the United States and Canada, Foster et al (2003), San Antonio et al (2006) Keefe and Rajnovich, (2007) and Doty et al (2012) reported on the Cash and Counseling programme which is an expanded model of consumer-directed care in that it provides a flexible monthly allowance that elderly Medicaid beneficiaries, can use to hire their choice of workers, including relatives, and to purchase other services and goods as states permit. Cash and Counseling requires elderly persons to develop plans showing how they would use the allowance to meet their personal care needs and provides counseling and fiscal assistance to help them plan and manage their responsibilities.

Elderly persons who are unable or unwilling to develop spending plans or manage their care themselves may designate a representative, such as a family member, to help them or do it for them. In various parts of Europe like United Kingdom, Norway, Sweden and so on, various types of cash for caregiver programmes also exist (Nixon, 2008; Ungerson, 2003). The same as seen in different parts of the world mostly developed countries cannot be said of developing countries like Ghana. The only incentive is the health the national health insurance and cover which even excludes many of the aged.

### **2.3.7 Informal Support for the Aged**

Within the research literature, two models of informal support have received the greatest attention. Shanas (1979) suggested that a principle of hierarchical substitution operates within an elder's informal network. Elders prefer to turn to close family members for support; spouses first, followed by adult children, siblings, more distant relatives, and finally friends and neighbors. From this perspective, formal services would only be sought in the absence of informal caregivers or when the demands of caregiving exceed the abilities of the informal network (Penning, 1990). This model suggests that married elders are most likely to receive support from a spouse.

In the absence of a spouse or in cases in which a spouse is also physically frail, help will be next most likely from an adult child. Elaborating on these ideas, Chappell (1989) and Tennstedt, Crawford, and McKinlay (1993) suggested that the individual with whom an older adult lives is most likely to provide assistance. Older adults with children, but no spouse, will be most likely to receive informal assistance when the adult child lives with the older person. In practice, however, it is difficult to disentangle help provided because of living arrangement from living arrangements that have been modified to provide care. Indeed, most extant data sets are insufficient to distinguish between preferred living arrangements and those selected

in response to an elder's needs for assistance (Pezzin, Kemper, & Reschovsky, 1996). An extension of this model of informal support was offered by Litwak (Litwak & Kulis, 1987; Silverstein & Litwak, 1993), who suggested that older adults' needs for assistance are matched to the individuals most likely to provide them.

For minimal assistance needs, such as help with shopping or transportation, friends and neighbors may be the most likely helpers. For more intensive and personal levels of care, however, family members will predominate among helpers. Studies also found differences in informal help by age. The old were far more likely than the younger age groups to be receiving informal assistance, although this effect appeared to be more pronounced for Swedes age 85 and older (5.29) than for those 85 and older in the United States (3.20). In neither country were those age 80 to 84 more likely than those age 75 to 79 to be receiving informal assistance, consistent with the idea that frailty is typically a phenomenon of very late life (Zarit, Johansson, & Berg, 1993; Zarit, Johansson, & Malmberg, 1995). According to Zarit et al, (1995) potential availability of kin support proved important for the receipt of informal support in both the United States and Sweden. In both countries, smaller proportions of individuals were receiving informal assistance when they lived alone; this was true to a lesser extent when individuals had children and was more pronounced in Sweden compared with the United States.

### **2.3.8 Gender Differences in Caregiving**

In general, ties between older persons and their children are strong bonds characterized by close geographical proximity, frequent contact and an intensive exchange of support in various areas. These typologies of parent-child relationships are found in the United States (Hanson & Sauer, 1985; Hooyman & Kiyak, 1988) as well as in northern European countries (Dooghe, 1994), including the Netherlands. A large proportion of Dutch older adults has at

least one child living within a thirty-minute traveling distance and interacts at least weekly with one or more children by phone or face-to-face (Dykstra & Knipscheer, 1995).

A nearly universal finding is that, next to the spouse, children provide the largest amount of emotional and instrumental support in the total network (Cantor & Little, 1985; Dykstra, 1993; Knipscheer, 1980). The intensity of support received from children varies with the particular needs and characteristics of both parents and children (Hess & Waring, 1978). The physical health of the parent is the most important determinant of the type and intensity of assistance needed (Horowitz, 1985). Children are among the first to respond to a declining state of physical health of the parent and to the corresponding increase in the need for various types of assistance (Miller & McFall, 1991). Large differences have been found between sons and daughters with respect to supportive behaviour toward parents.

The large bulk of literature on adult children as caregivers to their frail or impaired elderly parents has repeatedly shown that daughters are, next to the spouse, the most important providers of assistance to the parent (Dwyer & Coward, 1991; Johnson & Catalano, 1983). When sons do provide support to ill parents, they are more likely to provide assistance with different types of tasks (Matthews & Rosner, 1988). In general, sons provide occasional support with non-personal care tasks (repairing the house, doing small errands, yard work, and financial matters) whereas daughters assist with personal care tasks over a long period of time. These differences between the supportive behaviour of sons and daughters are only partly due to their different personal and social conditions (Dwyer & Coward, 1991), such as geographical distance, employment status, family status, and the sibling network.

Differences between the supportive behaviours of adult sons and daughters are also to be explained by the gender of the parent that is to be taken care of. Usually mothers are more likely to be supported by daughters, whereas fathers are likely to be supported by daughters

as well as by sons (Lee, Dwyer, & Coward, 1993). The larger prevalence of mother-daughter relationships in the care-taking of frail elderly is partly due to a demographic aspect: frail fathers are more likely to be still married and to be taken care of by their spouse, whereas frail mothers are more likely to be widowed and are dependent on the assistance provided by their children. In addition, mothers have indicated a preference for female caregivers over male caregivers (Finch & Mason, 1990), partly because ties between mothers and daughters are the most affectionate (Troll, 1987) and partly because the type of assistance needed is likely to be provided by daughters.

The latter also explains why daughters are likely to assist their fathers, although their bond is less affectionate than the bond with their mothers. The finding that fathers are also supported by their sons is more difficult to explain since father-son relationships are known to be relatively less close and more conflictive (Suito, Pillemer, Keeton, & Robison, 1995). Yet there is some evidence that fathers may prefer support from sons over daughters (Finch & Mason, 1990).

### **2.3.9 Effect of Caregiving on Marital Relationship**

The research literature suggests that marital relationships can be impacted in a number of different ways. If a husband or wife takes care of a child or elderly relative, this can have an effect on the marriage. Clearly, also, if the person receiving care is a marital partner, the relationship has been altered. In a study that looked at marital relationships of daughter caregivers, Suito and Pillemer (1994) found that the quality of the relationship declined when the husband was unsupportive or interfered in care giving. They found (not surprisingly) that husband's support was low when he perceived caregiving as interfering with the wife's traditional roles. In the case of head injury of a spouse, the reciprocity of the marital relationship is affected (Miller, 1990).

Eriksson et al. (2005) studied happiness in couples after brain injury and found that only 16 of 55 couples (29%) were satisfied with life as a whole and that joint experience of satisfaction was significantly related to the couple's functioning in everyday life, particularly in leisure time and social life. The authors conclude that greater inclusion of partners in rehabilitation is necessary. However, it should again be noted that the focus is on the welfare of the person with the disability. De Vugt and others (2003) found caregiver apathy in marriage where one has dementia with resulting decrease in communication. One study explored problem responses of caregivers to their care-receivers such as feelings of resentment or hostility. Predictors of anger and resentment include a restricted social life, many patient behavioural problems, a high level of burden and emotional liability of the care-receiver (Croog et al., 2006).

#### **2.4 Summary of literature**

The above literature review reveals that providing care for a chronically sick person can have harmful physical, mental, and emotional consequences for the caregiver. As family members struggle to care for others, they endanger their own health. Caregiver health is becoming a public health issue that requires more focused attention from health professionals, policy makers and caregivers themselves, to ensure the health and safety of those individuals dedicating their lives to the care of others (Family Caregiver Alliance, 2008). A critical examination of the literature reviewed however shows that not much attention has been paid to the intensity of the challenges faced by care givers specifically related to the aged with health challenges in Ghana. There may be a difference in the difficulty of caring for an aged without serious health challenges and one with chronic health conditions but these has not been adequately addressed by existing studies as reviewed.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

The techniques employed and the way they are applied in conducting any research can considerably affect the results of the study. Therefore, a judicious choice of methodology and how these methods are used can simplify and facilitate the collection and analysis of data (Kumekpor, 2002). This chapter discusses the various methods employed in answering the research questions.

#### **3.2 Target Population**

The population of the study is households in Adentan Municipality with an aged (60yrs+) family member with health challenges. The aged population 60+ accounts for about 19% of the total population of the municipality (Ghana Statistical Service, 2010).

#### **3.3 Sample and Sampling Technique**

A total of 80 households in all were sampled for the study. The study adopted a multi-stage sampling technique. Two communities, Adenta SSNIT Flats Community (urban) and Amrahia (rural) were purposively selected to provide rural-urban dimension of the discussions. A systematic random sampling technique was then employed to select 40 households from each of the two communities. In the case of Adenta SSNIT Flats, after choosing a household in a flat, 15 more flats were ignored before conducting the interview in the next available household with an elderly person. While a similar sampling technique was used to select 40 other households from Amrahia, 25 households had to be ignored in order to locate the next eligible household after starting the interviews from the north eastern side of the community.

Within each household between 1 and 2 family members/caregivers responsible for the upkeep of the aged were selected and one interviewed.

### **3.4 Research Design**

The study employed a single method approach. The method involved a quantitative technique which relied on questionnaires for data collection.

### **3.5 Study Area**

Adentan Municipality was mapped out from Tema Metropolitan Assembly in the year 2008. Adentan serves as a dormitory town for most people who have migrated from all over the country to seek employment in the industries and government institutions within the Tema-Accra Region.

#### **3.5.1 Location and Population**

The Adentan Municipal Assembly (with Adenta as its Capital) lies 10 Kilometers to the Northeast of Accra. The Municipality has a land area of about 85 sqkm (33sqmiles). It shares boundaries with Tema Metropolitan Assembly (T.M.A) in the east, Ga East Municipal Assembly in the West, Oyibi Township (part of the T.M.A) in the north and Madina a suburb of Ga East Municipal in the south. The Adentan Municipal Area has a population of 62, 715 when the 2000 population census was conducted, growing at a rate of 2.6%. There are 18 communities in the Municipality which include Adjiriganor, Amanfro, Amrahia, Ashale Botwe, Otano, Nmai Djorn and Ashiyie. The 2010 Population Census will now present the true population of the municipal when the figures are released by the Government Statistician.

### **3.5.2 Household Characteristics**

The Adentan Municipal Area has a population of 62, 715 when the 2000 population census was conducted growing at a rate of 2.6%. The age-sex structure of Adentan is influenced by n factors including natural birth rate, migration, mortality rate, socio–economic activities. Residents in Adentan are middle and high income earners.

### **3.5.3 Economy and Occupation**

Generally, residents in the Municipality are civil and public servants. Other workers who work in Accra also reside in the municipality. Most Farm lands in the Municipality are fast giving way to housing estates. There are still some farmers. Other economic activities being done include tourism hospitality industries transport services and trading. SSNIT Shopping centre is the biggest shop centre in the Municipality.

### **3.5.4 Health and Education**

There are a lot of private schools in the Municipality as compared to public schools; although the public schools are relatively few the individuals have taken initiative to set up private schools to augment the public ones. Besides this, formation of SMCs and functional Parent Teacher Associations (PTAs) are in all the schools both public and private. These are some few indications that, the people really have great interest in education.

### **3.6 Data Collection Instrument**

Self-administered socio-demographic questionnaire was designed for the purpose of this study. Respondents were assisted to fill questions to assess the health challenges of the aged and its effect on household wellbeing. The questionnaire comprised both open ended and close ended questions.

### **3.7 Sources of Data**

The researcher used both primary and secondary sources of data. The primary data was obtained from the field through questionnaires and interviews. The secondary data came from existing sources such as articles, journal, internet, books, and news prints.

### **3.8 Data collection Procedure**

Household with aged members/individuals were initially identified. The permission and consent of households identified sought and the respondents were identified. A convenient time was arranged with the participants purposively identified for the study. On the interview day the purpose of the study was explained to the participants after that the interviews were conducted and the questionnaires answered. The interviews took between 30-45 minutes. The interviews were mostly conducted in the local language for participants who were not comfortable with the use of the English Language.

### **3.9 Ethical Considerations**

The researcher followed scientifically the laid down procedure in obtaining data from respondents. The study was preceded by ethical clearance given by the Centre for Social Policy Studies (CSPS) in the form of a letter. There was informed consent from all the participants. Respondents were given the option to withdraw any time they were willing. Anonymity and confidentiality of respondents was ensured in the research. Participants were not exposed to any form of harm or psychological discomfort. The data collection lasted for 2 week. The data was obtained from 80 participants.

### 3.10 Data Analysis

Data collected were cleaned for consistency after which it was analyzed. The data collected through the use of questionnaire were subjected to quantitative in form of frequencies and percentages.



## CHAPTER FOUR

### RESULTS AND DISCUSSIONS

#### 4.1 Introduction

The study investigates the implications of health challenges of the aged on household's wellbeing in the Adentan Municipality. It specifically sought to assess the direct and indirect cost (man-hour lost) of caring for the aged with health challenges. Identify the effect of the health challenges of the aged on the household social life and also identify the effect of the health challenges of the aged on the health of the household member caregiver. Data collected from 80 caregivers with their corresponding aged family members they cater for are analyzed using descriptive tools of frequencies and percentages.

#### 4.2 Background Information on the Caregivers

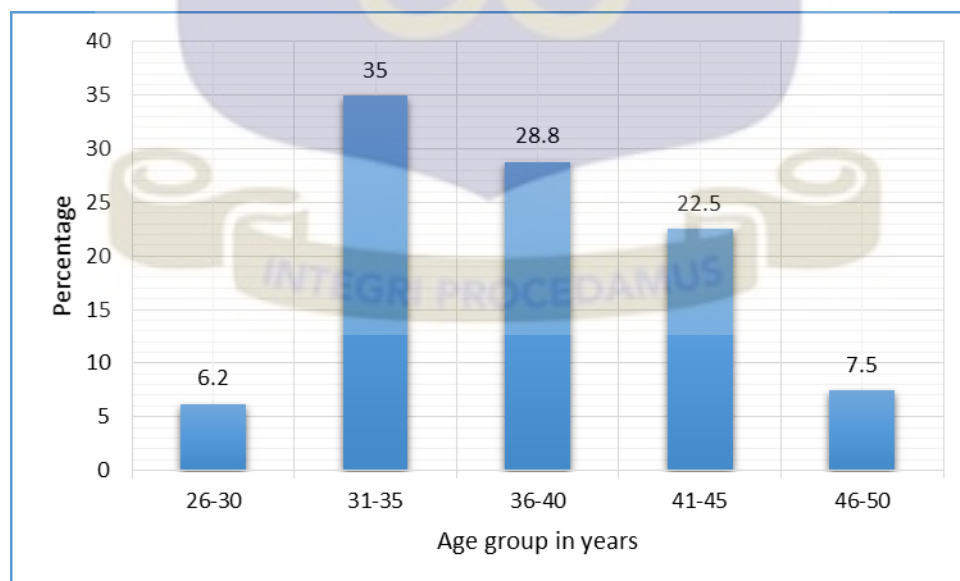
**Table 4.1: Relationship of care givers with the aged**

Relationship of care givers with the aged	Frequency	Percent (%)
Spouse	6	7.5
child 1	24	30.0
child 2	11	13.8
child 4	6	7.5
child 5	17	21.2
grandchild 2	5	6.2
grandchild 3	5	6.2
other relative	6	7.5
Total	80	100.0

*Source: Author's Field Research June, 2015*

A total of 58 caregivers representing 72.5% are children of the aged with health challenges while only 6 representing 7.5% are spouses of the aged they care for. Ten caregivers representing 12.4% are grand children while other relatives constituted 7.5% of the caregivers. This implies that the responsibility of caring for an aged family member with health challenges lies on their own children more than on other family members. This situation however, tends to support the breakdown of the extended family system as adduced by the modernization theory (Cowgill, 1986 cited in Mba, 2006). With only few spouses being found as caregivers of the aged, it could be assumed that many of the spouses themselves are also not healthy and equally need care. According to Dwyer & Coward (1991) and Johnson & Catalano (1983) however found spouses to be next to daughters in care giving. Literature on adult children as caregivers to their frail or impaired elderly parents has repeatedly shown that daughters are, next to the spouse, the most important providers of assistance to the parent

**Figure 4.1: Age of caregivers**

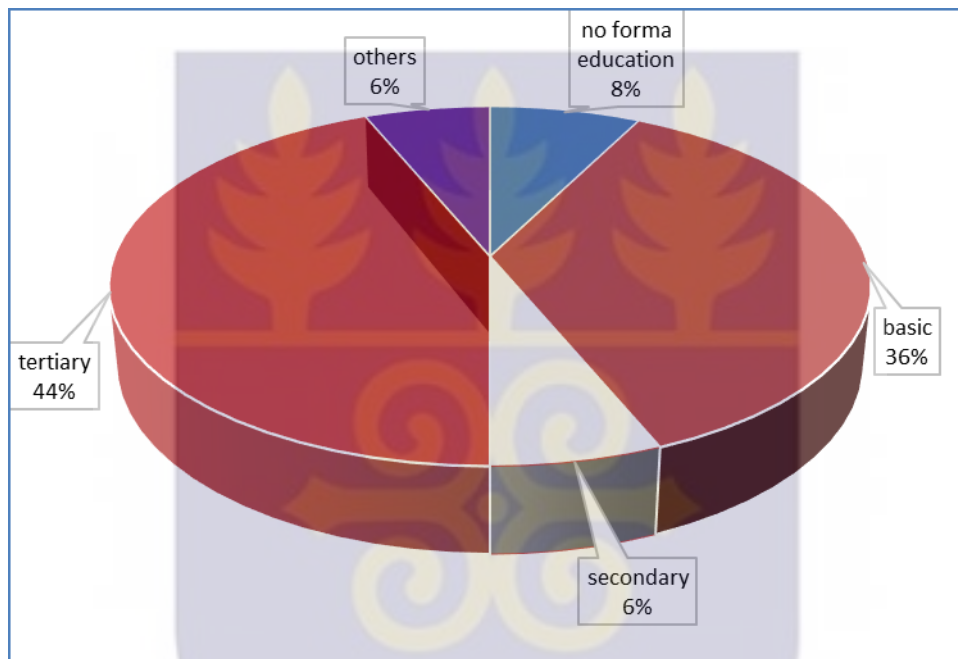


*Source: Author's Field Research June, 2015*

The age of the caregivers of the aged with health challenges ranged between 26-50 with majority falling within age group 31-45. Those within age 31-35 were 28 representing 35%

of the sample while those within ages 36-40 were 23 representing 28.8%. Ages 41-45 were 18 representing 22.5% while only 6 representing 7.5% are from 46 and above. This implies that more of the caregivers are within their active youthful age or at a productive age but are not working due to the responsibility of caregiving.

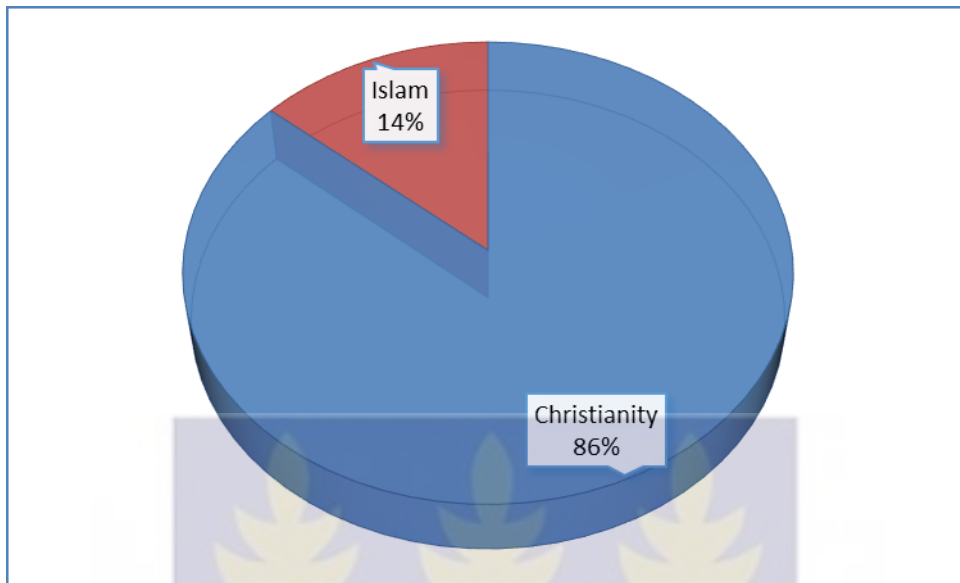
**Figure 4.2 Educational acquisition**



*Source: Author's Field Research June, 2015*

With educational achievement as in Figure 3.2 above, 29 representing 36.2% had basic education, 5 representing 6.2% had secondary education. Majority of 35 representing 43.2% had some form of tertiary education. This is consistent with the category of people who are mostly the caregivers, i.e. children of the aged. Six representing 7.5% however had no formal education.

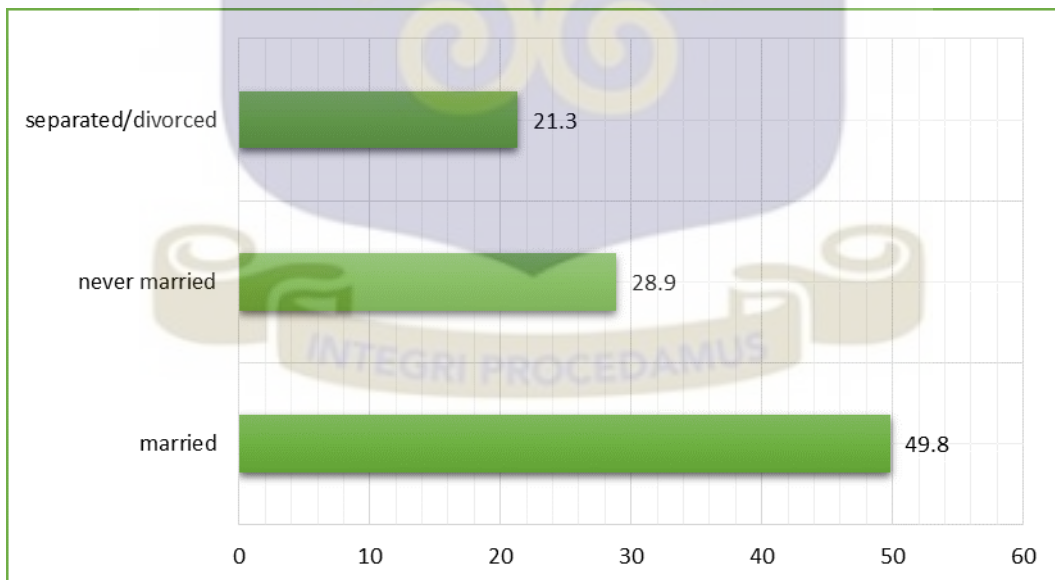
**Figure 4.3: Religion of caregiver**



*Source: Author's Field Research June, 2015*

Sixty nine representing 86.2% of the caregivers are Christians while Muslims were 11, representing 13.8%.

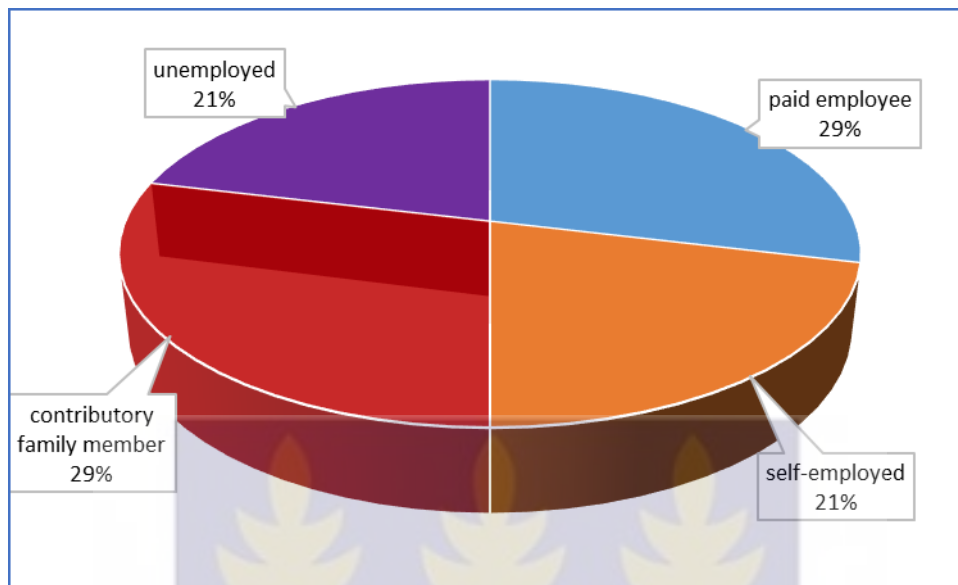
**Figure 4.4: Marital status**



*Source: Author's Field Research June, 2015*

Of the female respondents, 49.8% are married, 28.9% have never married while 17 representing 21.3% have either divorced or separated from their spouses.

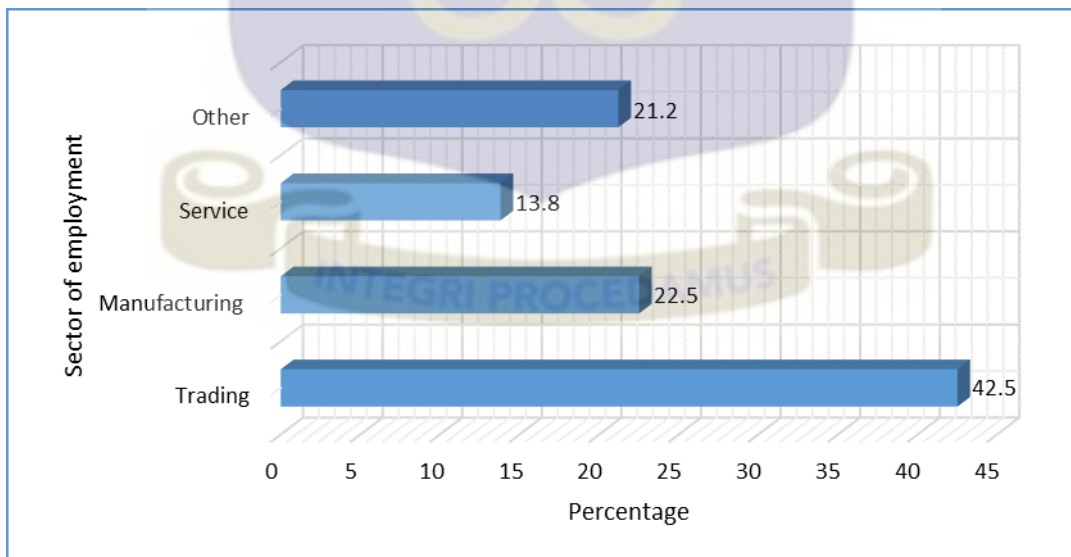
**Figure 4.5: Employment status**



*Source: Author's Field Research June, 2015*

In terms of employment of the caregivers, 23 representing 28.8% are in paid formal employment, 17 representing 21.2% are self-employed, and 23 are contributory family member While 17 representing 21.2% are unemployed.

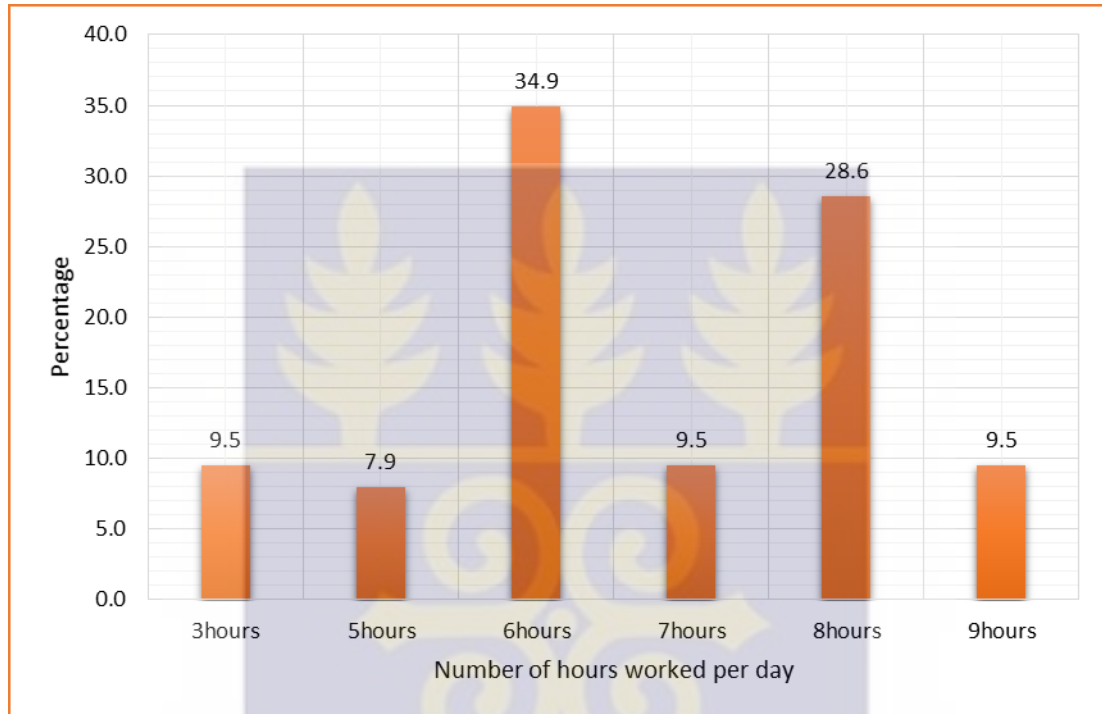
**Figure 4.6: Sector of Employment**



*Source: Author's Field Research June, 2015*

Of the number employed, 34 representing 42% are into trading, 18 representing 22.3 are into manufacturing while the rest 11 representing 13.8 are in the service sector such as bankers, teachers, etc.

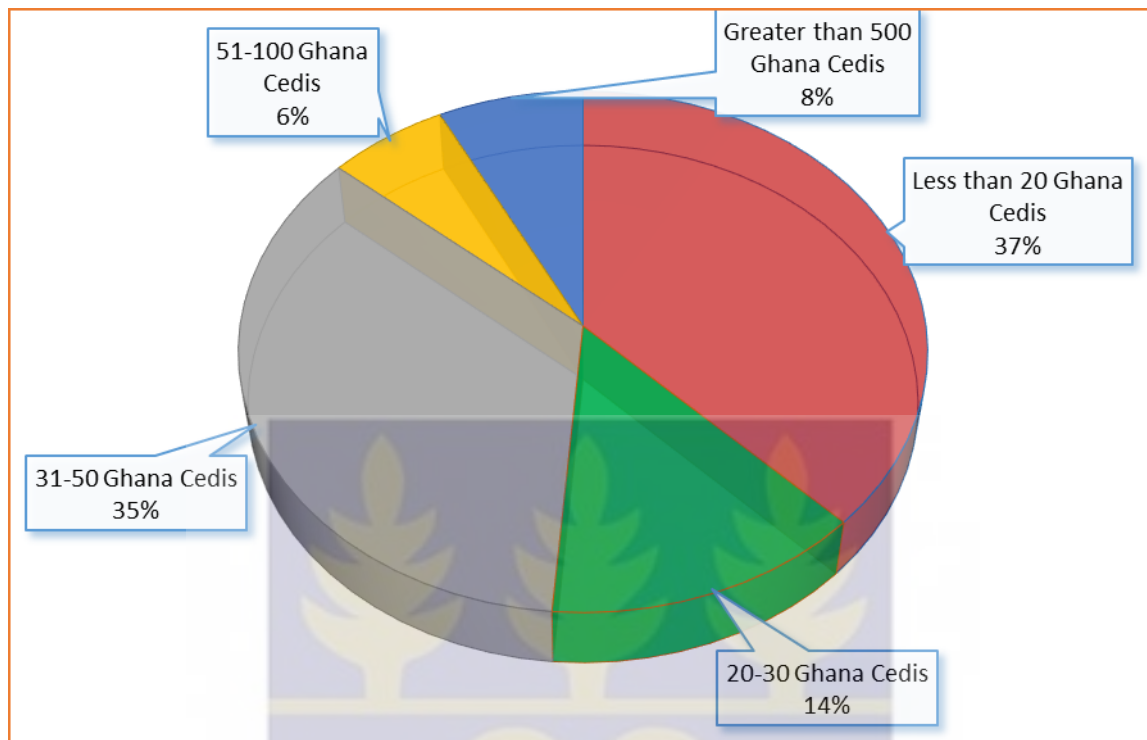
**Figure 4.7: Average hours worked per day**



*Source: Author's Field Research June, 2015*

Of the same number that is in some form of employment, 7.5% works 3 hours per day, 6.2% works 5 hours per day, majority of 22 representing 27.5% works 6hrs per day while another 7.5% works 7 hours per day. Those who works for 8 hours and more totaled up to 24 representing 29.3% of the working class of the caregivers.

**Figure 4.8: Income per day**

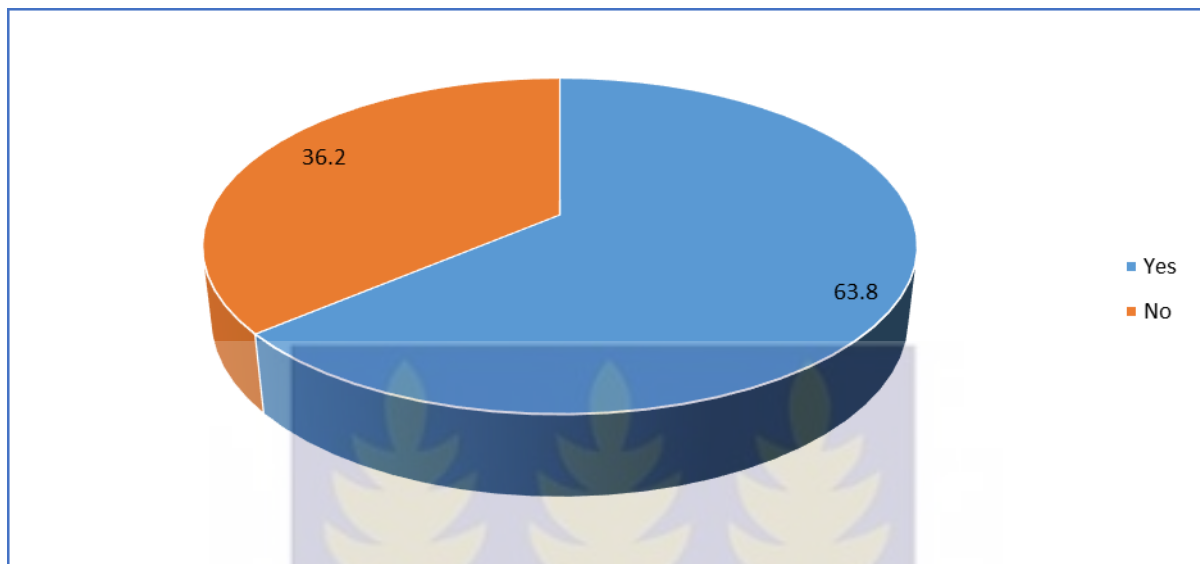


*Source: Author's Field Research June, 2015*

All the caregivers earn some form of income even including the unemployed. Majority of 30 representing 37.5% earn less than 20 Ghana Cedis per day, 11 representing 13.8% earn 20-30 Ghana Cedis, 28 representing 35% earn 31-50 Ghana Cedis while a total of 11 representing 13.7% earn from above 50 Ghana Cedis to as high as 500 Ghana Cedis.

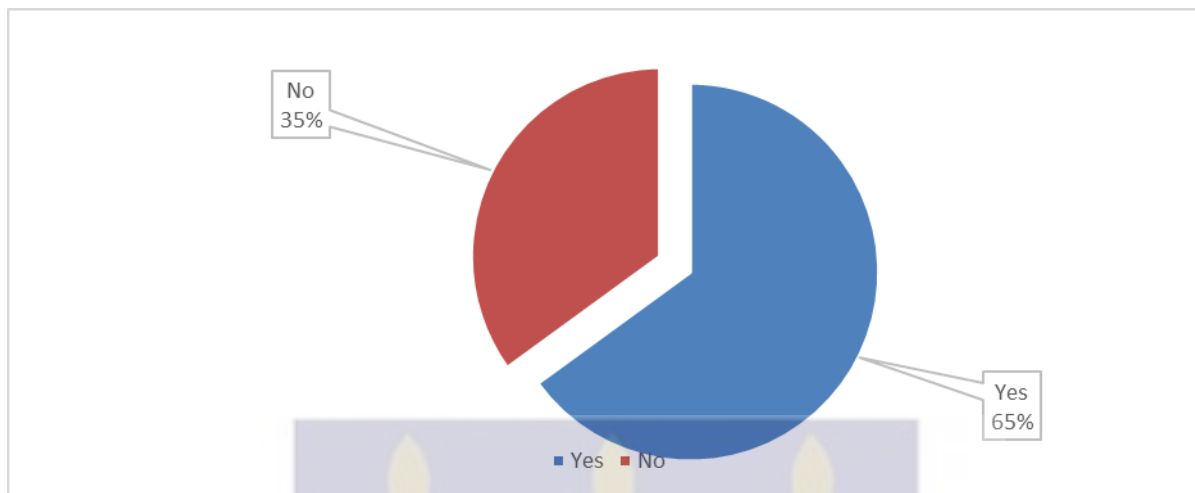
### 4.3 Caregiving and Social Life

**Figure 4.9: Effects of caring for the aged family member and worshipping activities**



*Source: Author's Field Research June, 2015*

When asked whether taking care of the aged family member interfered with their worship activities, 51 representing 63.8% indicated yes. They explained that the time they have to go to church usually is the time they have to be at home doing one thing or the other for the aged. For example, medication has to be given at a specific time when one should be in church. Time for evening worship is also unavailable according to a cross section of the participants because one would be tired after preparing the food, and in some cases bathing the aged. Participants who are Muslims indicated they are unable to join their colleagues in the mosque most of the time, so they do their prayers alone or together with other family members if they are available.

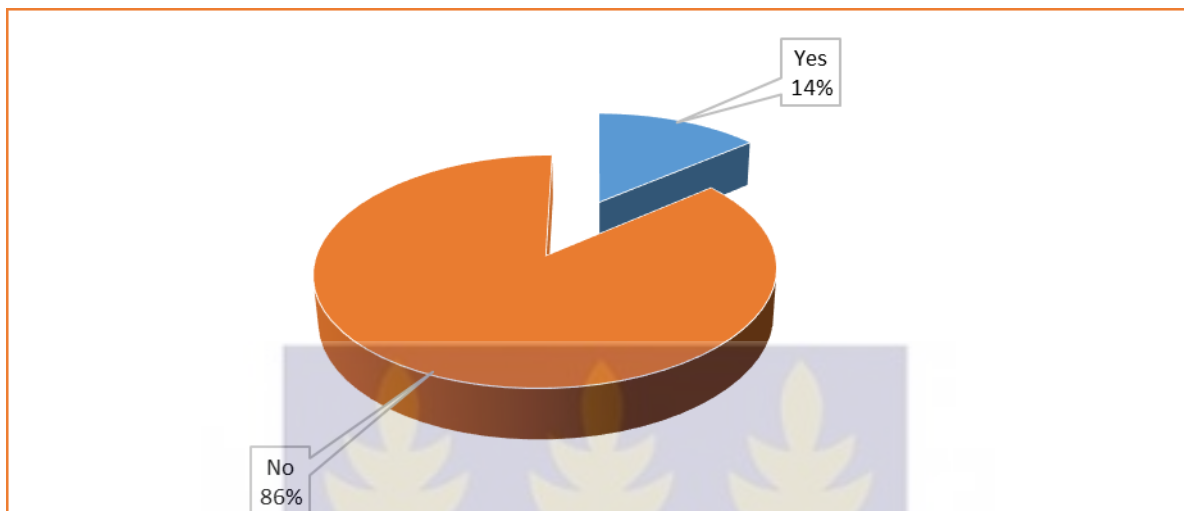
**Figure 4.10: Effects of caring for the aged family member on relationship with friends**

*Source: Author's Field Research June, 2015*

When asked whether taking care of the aged family member interfere with their relationship with friends 52 representing 65.0% indicated “yes.” They remarked that they can no longer go out or sit for a long time to chat with friends because the aged needs much attention. It is their friends who rather visit them occasionally “and once you don’t return the visit that is the end.” These days they contact one another through the use of phones; but they cannot talk much like being physically present.



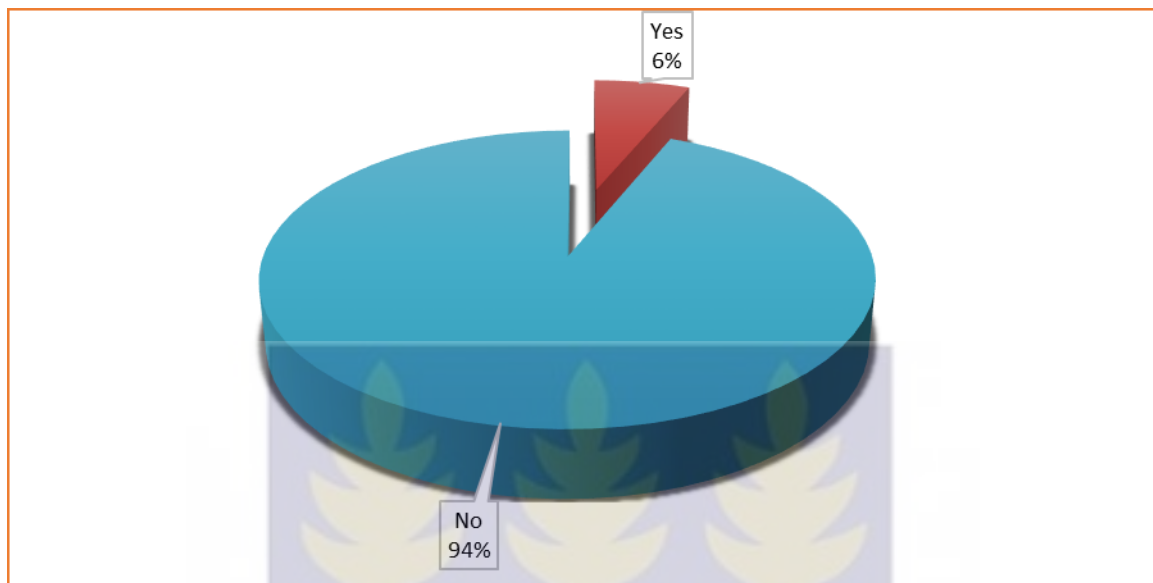
**Figure 4.11: Do you still make time to go out for entertainment aside taking care of the aged family member?**



*Source: Author's Field Research June, 2015*

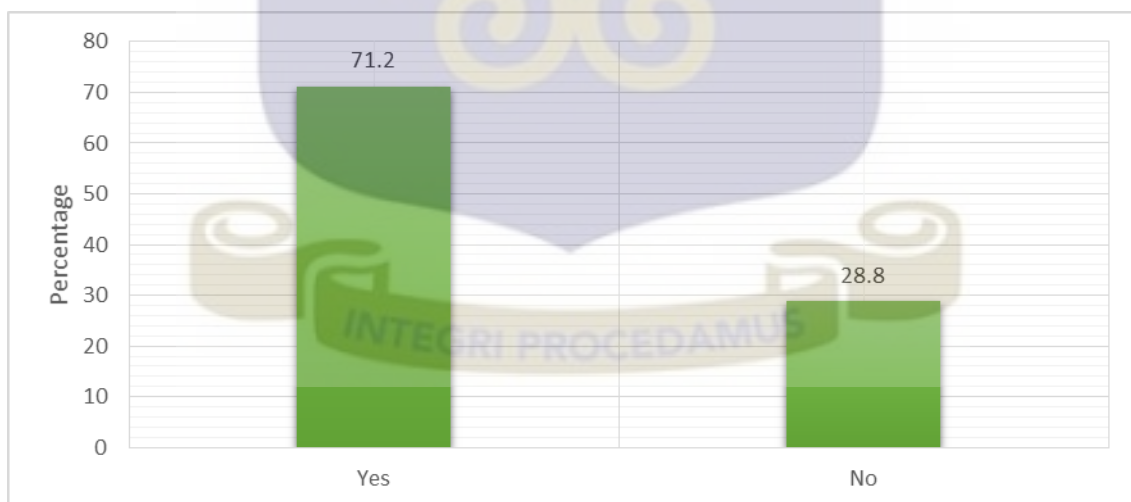
In likewise manner, as in relationship with friends, when asked whether they still made time to go out for entertainment aside taking care of the aged family member, 69 representing 86.2% of the caregivers indicated "no." The same reasons that are unable to have time for their friends and even worship (see Figure 4.9 and 4.10 above). Similarly, a majority of 75 representing 93.8% indicated they could not attend any form of social gathering because of the task of caregiving (see Figure 4.12 below). According to the caregivers this makes them appear antisocial to many who do not know their predicaments. According to a participant, she was compelled to relinquish her position as a group leader in church because of punctuality and absenteeism problems.

**Figure 4.12: Are you able to attend social gatherings like funerals aside taking care of the aged family member?**



*Source: Author's Field Research June, 2015*

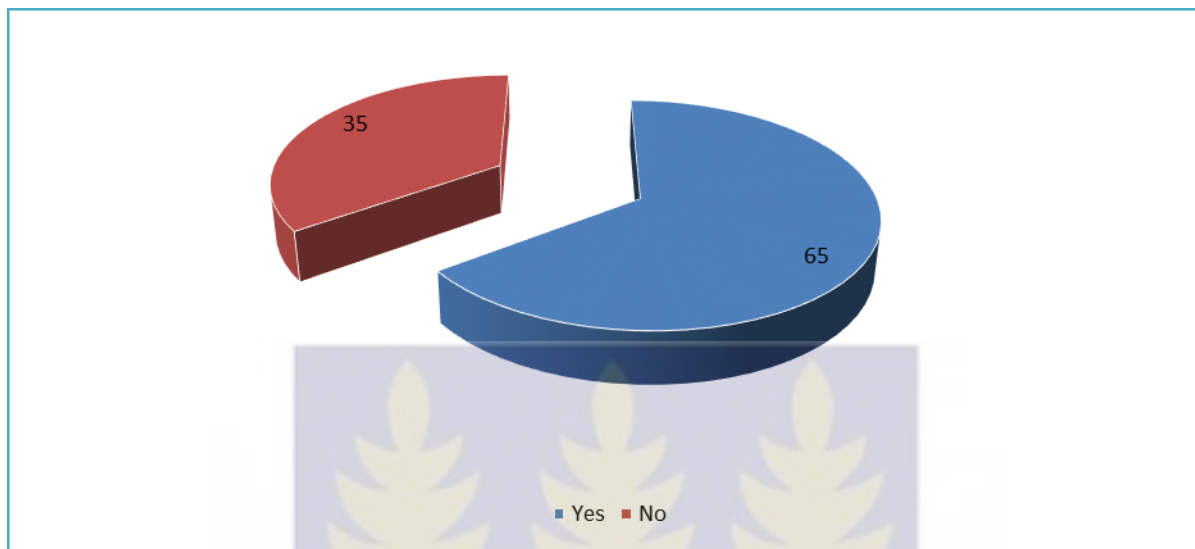
**Figure 4.13: Do you have time to watch movies or listen to music or enjoy your past time aside taking care of your aged family member?**



*Source: Author's Field Research June, 2015*

As for watching movies or listening to music or enjoying some past time 57 representing 71.2% indicated, "yes." According to them they are able to do this when they are in bed or asleep. Sometimes they stay together with the aged person and watch movies.

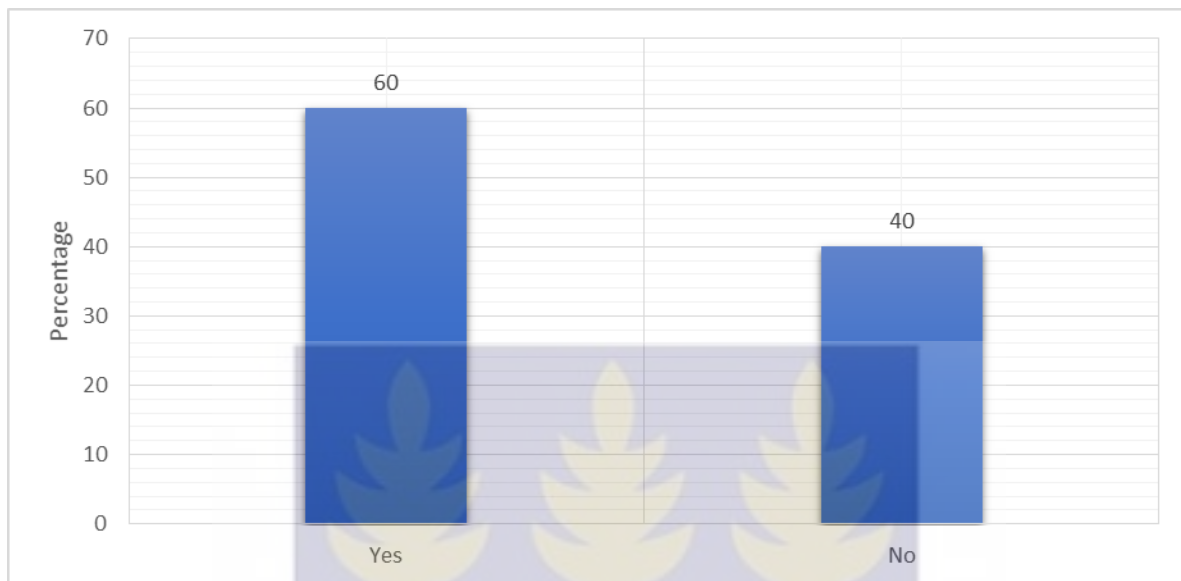
**Figure 4.14: Will you say your social life is affected as a result of assuming responsibility of taking care of the aged family member?**



*Source: Author's Field Research June, 2015*

From the Figure 4.14 above, a majority of 57 representing 71.2% could confidently say that they don't have the best of social life as result of assuming responsibility of taking care of the aged family member. This indication is not surprising since they earlier mentioned challenges with relationship with friends and worship. Studies have found in support of the above finding that family caregivers can be negatively affected by the care they give. The effect can be social and psychological, such as taking unpaid leaves from their jobs, reducing work hours, rearranging their schedules, and restricting their social contacts (Stoltz, Uden & Willman, 2004)

**Figure 4.15: Do you see the responsibility of taking care of your aged family member as interfering with your marital responsibilities?**

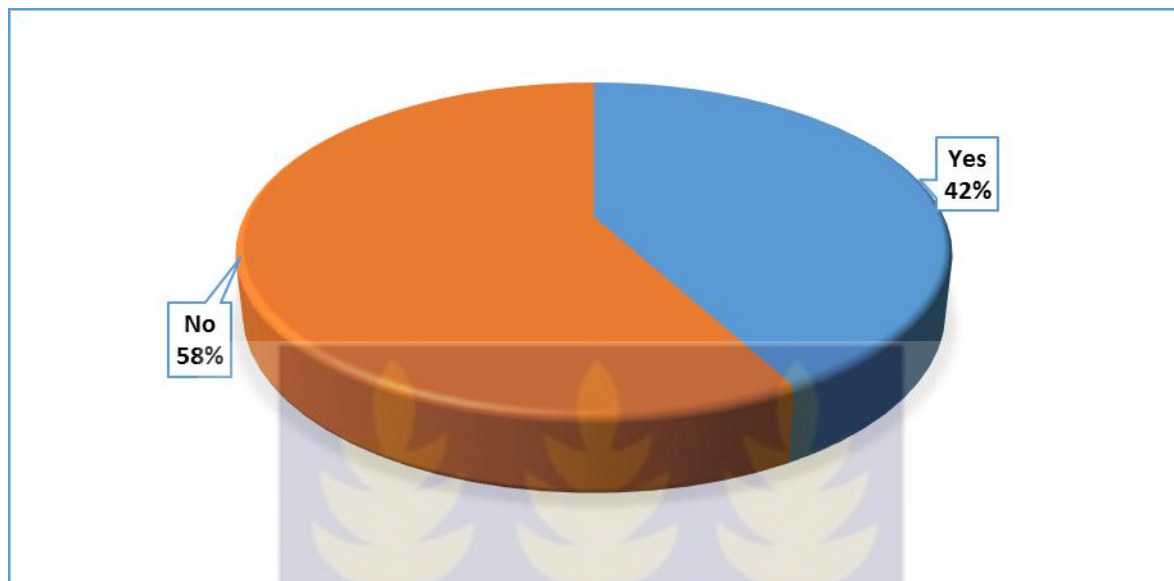


*Source: Author's Field Research June, 2015*

For those married who numbered 42, 24 representing 60% indicated that the responsibility of the caregiving affected their marital obligations. According to some, their spouses live apart from where the aged family lives so they always have to abandon their spouses and in many cases leave them in the care their children.



**Figure 4.16: Will you attribute being single partly to the responsibility taking care of your aged family member?**



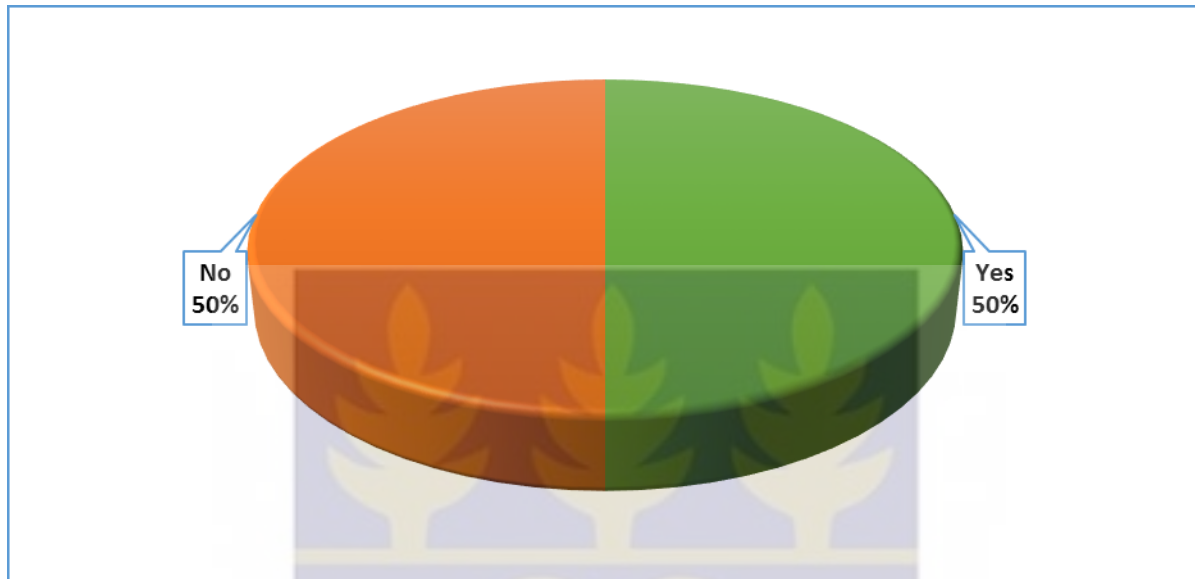
*Source: Author's Field Research June, 2015*

For those single and divorced/separated participants, 16 of them representing 21.1% attributed their being single or divorced to the responsibility of taking care of the aged but majority of them, 22 representing 29.0% of the sample indicated no. some said they had the marital issues before even assuming the responsibility and some said they could simply not find a partner yet.



#### 4.4 Caregiving and Health of the Caregivers

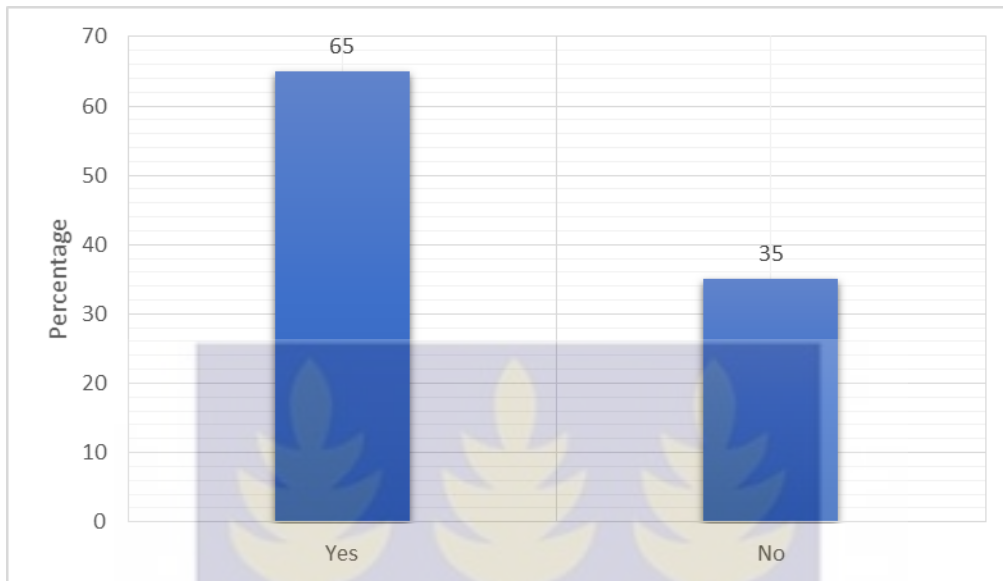
**Figure 4.17: Do you often fall sick as a result of the responsibility taking care of your aged family member?**



*Source: Author's Field Research June, 2015*

When asked whether they often fell sick as a result of the responsibility taking care of your aged family member, 40 representing 50% said yes while 40 representing another 50 % said no. This means half of the caregivers sampled often fell sick themselves and related their problem to the responsibility of caring for the aged. Some of them remarked that the work was tedious that they had to sometimes seek assistance from other family member. For example, having to carry the individual from the room to the bathhouse and back.

**Figure 4.18: Do you undergo emotional stress or develop any form of psychological effect from the responsibility of taking care of your aged family member?**



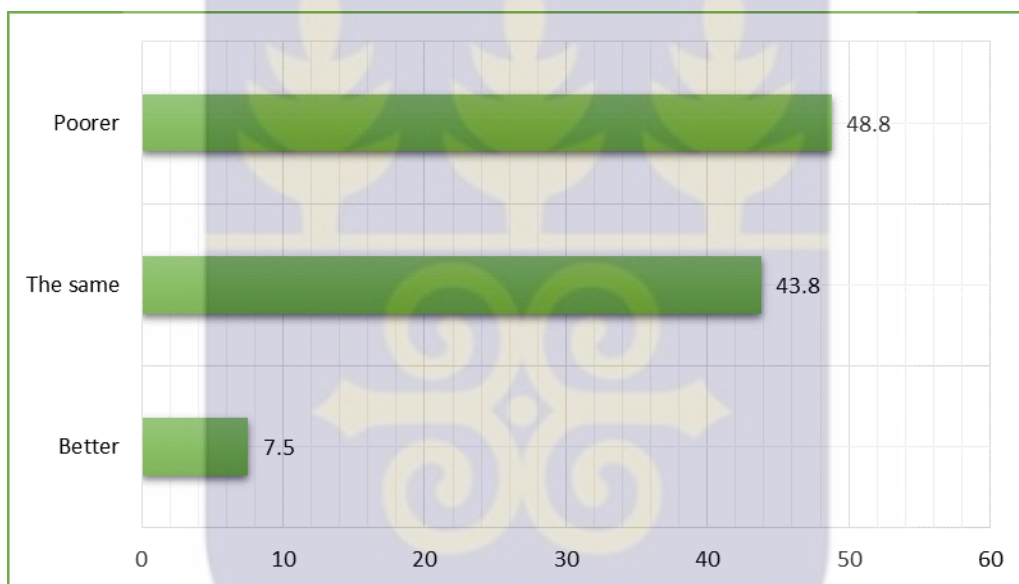
*Source: Author's Field Research June, 2015*

Majority of 52 representing 65.0% indicated undergoing emotional stress or developing some form of psychological effect from the responsibility of taking care of your aged family member. This they attributed to the demanding nature of the work and sometimes the financial demands as well. According to some of them as you are thinking of the work involved in care such as cooking, bathing them, washing, taking them to hospital and reviews etc, you are also thinking of the financial aspect which can be a bit demanding psychologically. Goldzweig et al. (2013) reported that among the research group of caregivers, levels of psychological distress were almost double in comparison to the healthy control group. Caregivers reported lower levels of social support and low levels of coping behaviours which correlated negatively to distress. Increased ages of patients accentuated caregivers' distress.

Similarly in support of the finding there is cumulative consistent evidence that informal caregivers for elderly cancer patients experience high rates of anxiety and depression, with

20–30% of all caregivers believed to be at high risk for psychiatric morbidity. Estimates show that between 40 and 70% of caregivers have clinically significant symptoms of depression, with approximately one quarter to one half of these caregivers meeting the diagnostic criteria for major depression (National Alliance for Caregiving (NAC) & AARP, 2008, 2009).

**Figure 4.19: How would you assess your health status from the time you assumed the responsibility if taking care of your aged family member compared to before?**



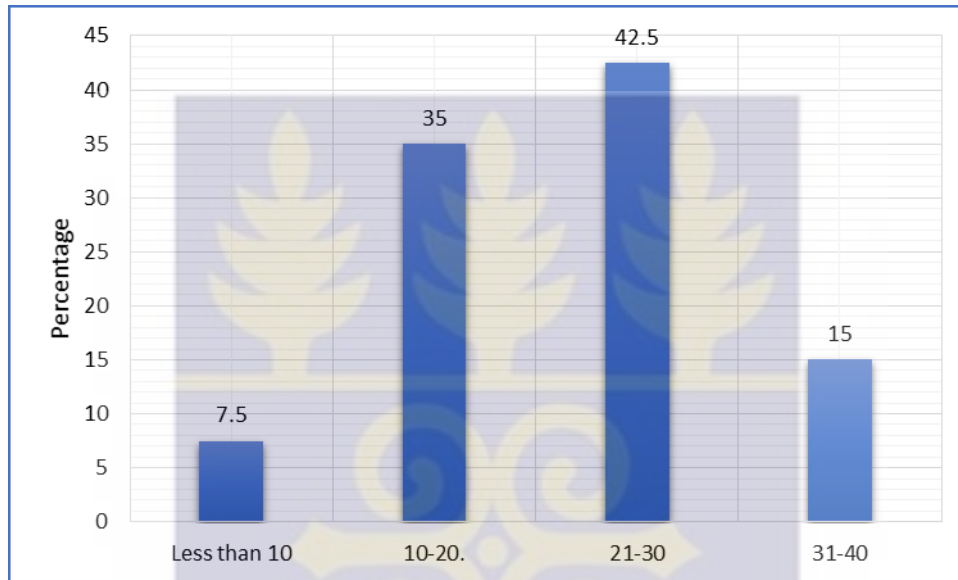
*Source: Author's Field Research June, 2015*

When asked how they would assess their health status from the time you assumed the responsibility taking care of your aged family member compared to before, majority of 39 representing 48.8% rated it as poorer, while 35 representing 43.8 rated it as the same. Only 6 representing 7.5% rated it as better. This implies that majority of the caregivers can say the responsibility of care giving has taken some toll on their health even though about half of them don't fall sick physically as indicated in Figure 3.19 above. The health effect may come as a result of excessive fatigue or stress. Some of the participants remarked that as you

spend the whole discharging your duties you even get no time to rest until the person goes to bed in the night.

#### 4.5 Caring for the aged with health challenges and Family finances

**Figure 4.20: Approximately what percentage of family's financial resources do you spend on the aged family member?**

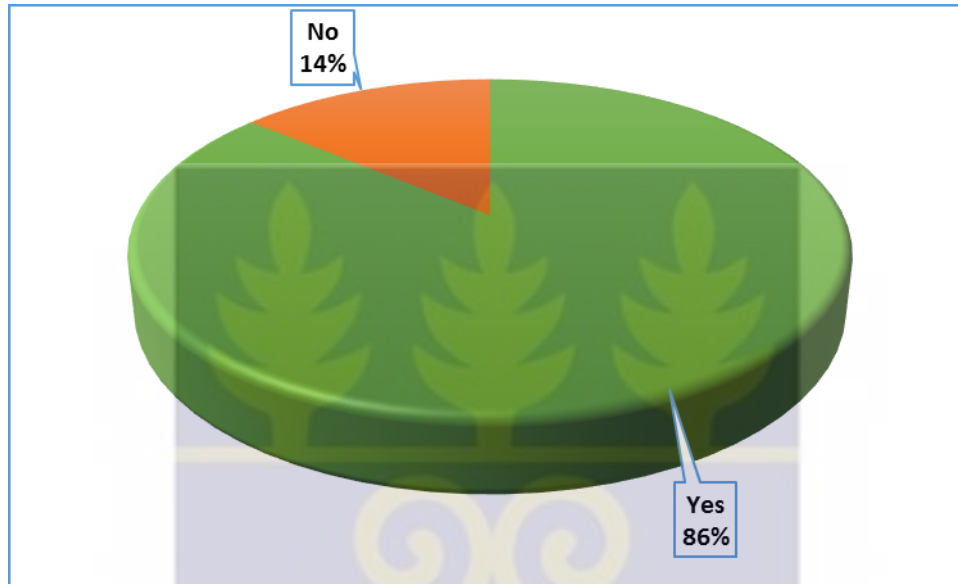


*Source: Author's Field Research June, 2015*

From the Figure 4.20 above, a total of 46 representing 57.5% indicated more than 20% of the families financial resources are spent on the aged the remaining 34 representing 42.5 spends 20% or less of the families' financial resources on the aged. According to the participants, there are other family members whose care even demands more than what is spent on the aged. For example in some cases where he first child is the care giver, the other children and siblings are a students in some in tertiary institutions. The situation they indicated puts so much pressure and strain on the families' financial resources as indicated by majority of 69 representing 86.2% (see Figure 4.21 below). According to an empirical finding which supports the above finding, care giving imposes considerable direct financial and economic

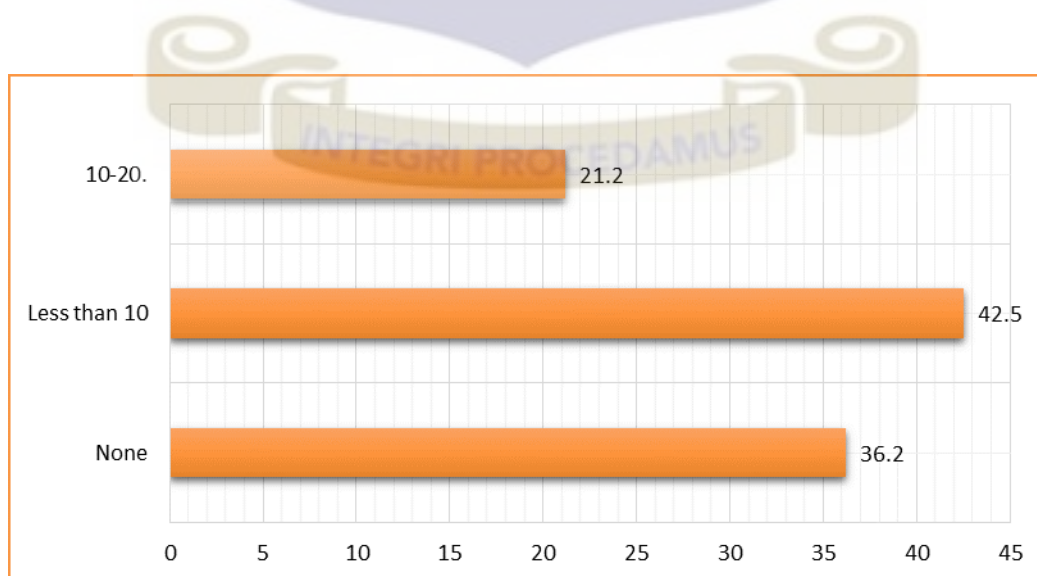
costs on caregivers and their families such as medical services, medical devices, drugs, food, clothing, and personal items for the elderly. Chorn-Dunham and Dietz, (2003)

**Figure 4.21: Do you see the expenditure you make on the aged person as a strain on the family's finances?**



Source: Author's Field Research June, 2015

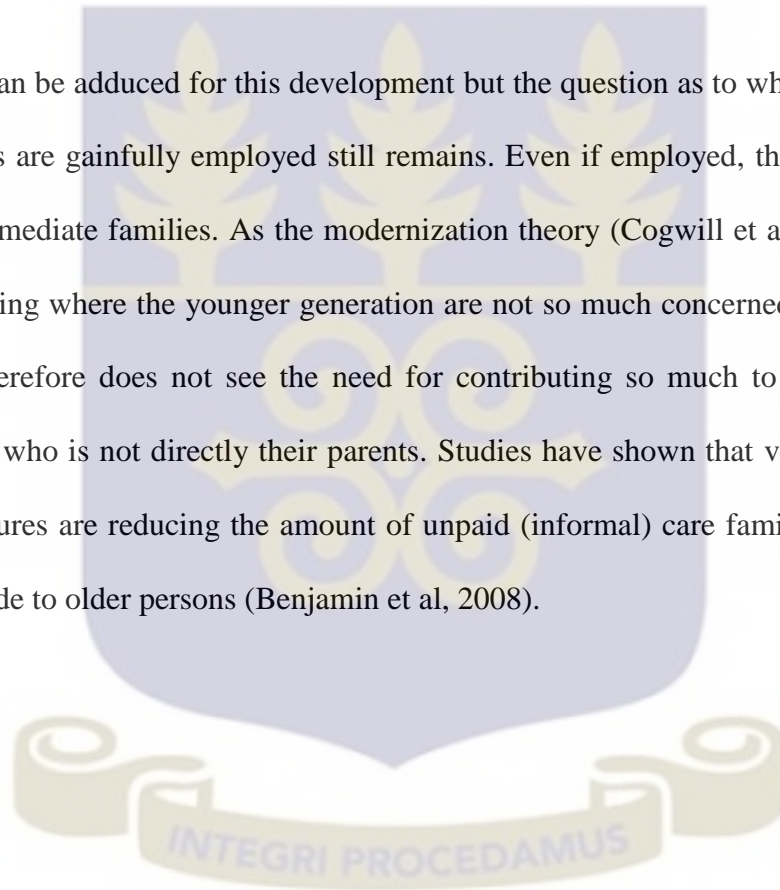
**Figure 4.22: What percentage of what you spend on the aged family member do other family members contribute (monthly contribution)**



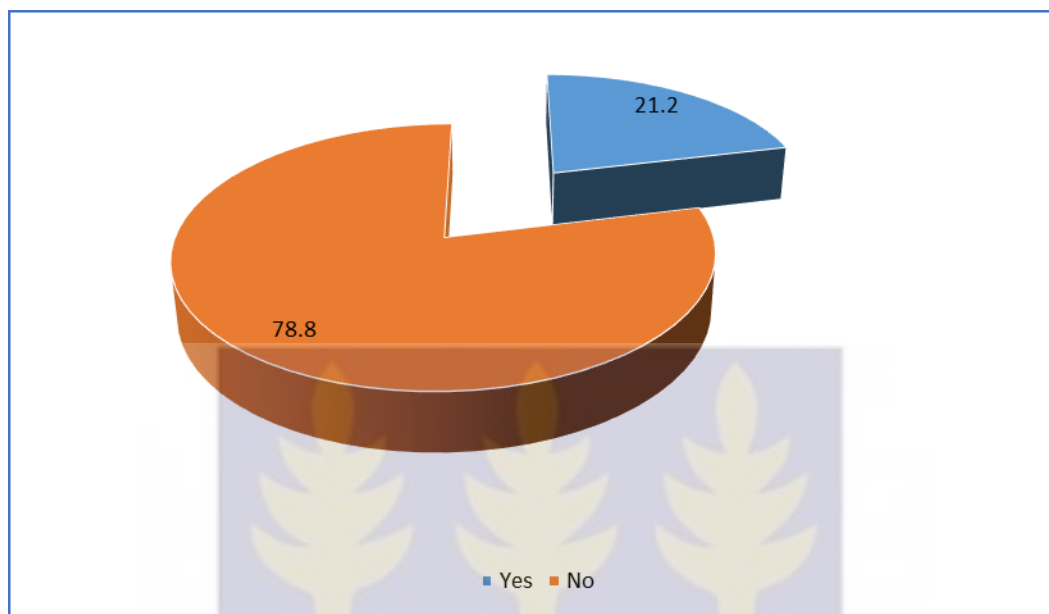
Source: Author's Field Research June, 2015

According to the participants, other family members add very little to the care of the aged family member. Twenty nine representing 36.2% indicated that other family members contribute nothing, 34 representing 42.5% indicated other family members contribute less than 10% and 17 representing 21% mentioned between 10-20% contributions from other family members towards the upkeep of the aged member. It can therefore be noted from the above finding that the financial responsibilities have become that solely of the breadwinners and very few who are closely related to the individual that needs care.

Many reasons can be adduced for this development but the question as to whether those other family members are gainfully employed still remains. Even if employed, they tend to attend to their own immediate families. As the modernization theory (Cogwill et al, 1986) explains times are changing where the younger generation are not so much concerned about extended families and therefore does not see the need for contributing so much to help cater for a family member who is not directly their parents. Studies have shown that various social and economic pressures are reducing the amount of unpaid (informal) care families are able and willing to provide to older persons (Benjamin et al, 2008).



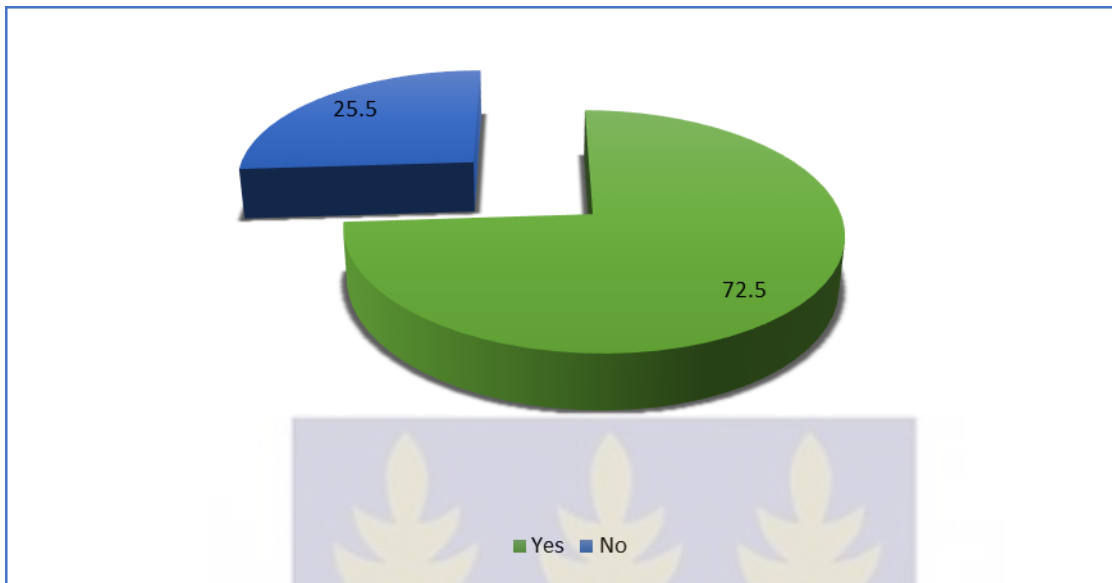
**Figure 4.23: Do you always have enough resources to take care of the aged family member and yourself?**



*Source: Author's Field Research June, 2015*

Majority of the participants 63 representing 78.8% do not have enough resources to discharge their care giving duties. Only 17 representing 21.3 percent indicated they have some resources. Even these are caregivers of the aged who have some personal investments and business enterprises before taking ill. The non-availability of the resources made quite a significant number (58 representing 72.5%, see Figure3.24 below) of the caregivers to sometimes borrow to cater for the aged.

**Figure 4.24: Do you sometimes have to borrow to take care of the aged family member?**



*Source: Author's Field Research June, 2015*

**Figure 4.25: What percentage of family's income goes into the aged's medical expenses?**



*Source: Author's Field Research June, 2015*

Aside other expenses, medical expenses alone, 11 representing 13.8% said 46 representing 57.5% indicated less than 10% while 13 representing 16.5% mentioned 10-30%. Ten respondents, representing 12.5% said that 30% of as medical expenses for the aged is drawn from family's financial resources (see Figure3.25 above). This puts further pressure on the

families' resources as some of the ailments of the aged are terminal and will require medical care till they die. Lack of effective implementations of national health policies on the aged can partly be blamed for this development. The national health insurance is not favoring majority of the aged who have health challenges therefore, families have to take up their medical expenses.

**Figure 4.26: Does catering for the aged family member interfere with your work?**



*Source: Author's Field Research June, 2015*

For the 40 paid and self-employed, when asked whether catering for the aged family member interfered with the work they do, majority of 30 representing 75% indicated yes. According to them they have to constantly take time off work, ask permission to come home and take care of their aged family member. These excuses from duty therefore affects their performance at work and productivity in general. According to a participant, she had to quit a job because the organization will not tolerate such excuses. The few who indicated no are those in private business who have assistants. For example some own boutiques and have trained shop assistants to take charge in their absence.

Empirical studies corroborate the above finding that many caregivers in the workforce have to deal with issues such as lost wages, job security, career paths and employment benefits such as health insurance and retirement savings and so on (Chorn-Dunham and Dietz, 2003). This is because due to their caregiving (depending on the intensity) they may have to do the following making changes in the workplace, arriving late, leaving early or taking time off, taking a leave of absence, dropping back to part time, giving up work entirely and sometimes turning down promotions (Nixon, 2008). All these can lead to lost wages and other problems. Also because caregiving may conflict with caregivers' employment potential, it may generate productivity losses for the economy as a whole.



#### 4.6 Information on the Aged

**Table 4.2: Type of employment of the aged and income received during active period of working**

variable		Frequency	Percent (%)
Age	60-65	17	21.2
	66-70	22	22.5
	71-75	25	31.2
	76-80	11	13.8
	Above 80	5	6.2
Status of work in active days	paid employee- formal	38	47.5
	paid employee-informal	22	27.5
	self employed	19	23.8
	Others	1	1.2
Current Source of income	Remittances	34	42.5
	Investment	37	46.2
	Insurance	6	7.5
	Others	3	3.8
Currently Income per month	< 20 Ghana Cedis	3	3.8
	20-30 Ghana Cedis	6	7.5
	31-50 Ghana Cedis	11	13.8
	51-100 Ghana Cedis	17	21.2
	110-200 Ghana Cedis	14	17.5
	210-500 Ghana Cedis	15	18.8
	> 500 Ghana Cedis	14	17.5

Source: Author's Field Research June, 2015

Majority of the aged with health challenges are between 66 and 75yrs. Out of the sample 60 representing 75% were in paid employment while 19 representing 23.8% were self-employed. The major sources of income or remittances 34(42.5%), investment 37 (46.2%). For income per month, 48 representing 60% of the aged earns between 20 to 200 Ghana Cedis while 29 representing 36.3% earns over 200 Ghana Cedis. Only 3 earn less than 20 Ghana Cedis.

**Table 4.3: Type of health challenge of the aged and cost of treatment**

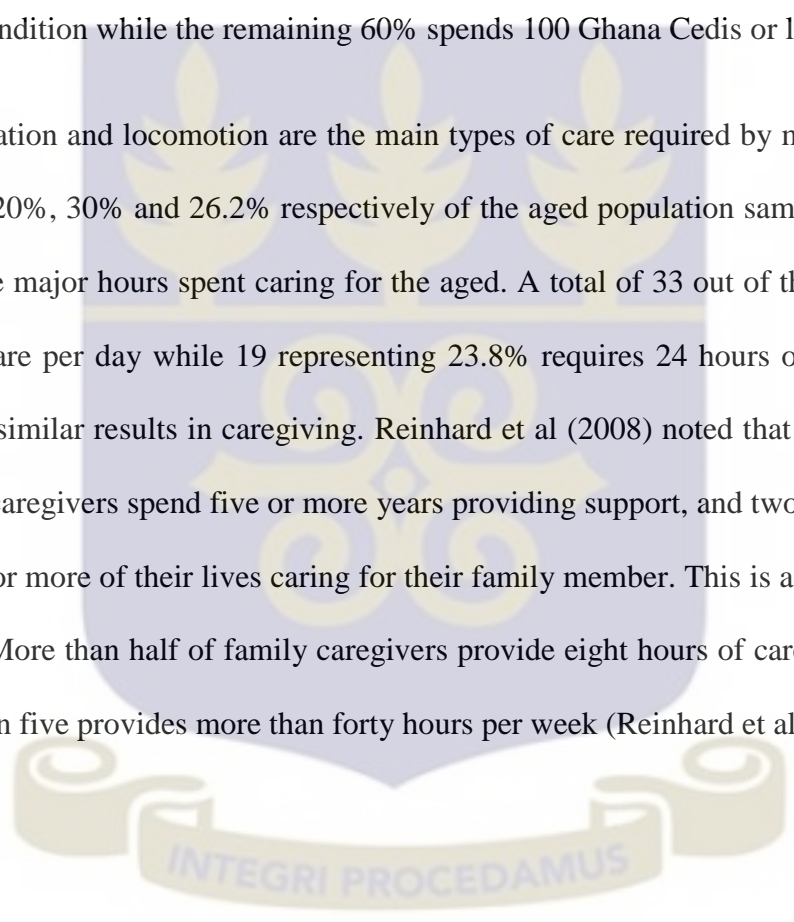
Variable		Frequency	Percent (%)
Type of sickness	Dementia	5	6.2
	Parkinson	5	6.2
	Arthritis	5	6.2
	Stroke	21	26.2
	Diabetes	6	7.5
	Hypertension	16	20.0
	Blindness	11	13.8
	Cancer	4	5.0
	Depression	3	3.8
	Others	4	5.0
Monthly cost of treatment	< 200	2	2.5
	20-30	4	5.0
	31-50	12	15.0
	51-100	30	37.5
	110-200	16	20.0
	210-500	14	17.5
	>500	2	2.5

Source: Author's Field Research June, 2015

The major sources of income are remittances 34 (42.5%), investment 37 (46.2%). for income per month, 48 representing 60% of the aged earns between 20 to 200 Ghana Cedis, while 29 representing 36.3% earn over 200 Ghana Cedis. Only 3 earns less than 20 Ghana Cedis.

Stroke and hypertension were the major ailments suffered by the aged accounting for 26.2% and 20% respectively. It has been identified that some even have multiple challenges for instance stroke and dementia. Thirty two representing 40% spend above 100ghs monthly on treating their condition while the remaining 60% spends 100 Ghana Cedis or less.

Feeding, medication and locomotion are the main types of care required by most of the aged accounting for 20%, 30% and 26.2% respectively of the aged population sampled. Six, 7 and 24 hours are the major hours spent caring for the aged. A total of 33 out of the 80 requires 6 to 7 hours of care per day while 19 representing 23.8% requires 24 hours of care. Existing research found similar results in caregiving. Reinhard et al (2008) noted that on the average, four out of ten caregivers spend five or more years providing support, and two out of ten have spent a decade or more of their lives caring for their family member. This is a day-in, day-out responsibility. More than half of family caregivers provide eight hours of care or more every week, and one in five provides more than forty hours per week (Reinhard et al, 2008)



**Table 4.4: Type of care needed by the aged and hours spent on them**

variable		Frequency	Percent (%)
Type of care needed	Bathing	5	6.2
	Feeding	16	20.0
	Medication	24	30.0
	Locomotion	21	26.2
	Errands	14	17.5
Hours spent on care per day	1 hours	1	1.2
	2 hours	4	5.0
	3 hours	2	2.5
	4 hours	3	3.8
	5 hours	7	8.8
	6 hours	15	18.8
	7 hours	18	22.5
	8 hours	4	5.0
	9 hours	5	6.2
	10 hours	1	1.2
	11 hours	1	1.2
	24 hours	19	23.8

*Source: Author's Field Research June, 2015*

#### 4.7 Summary of findings

**The following findings were made from the study;**

- ❖ The aged with health challenges are mostly being cared for by their children. A total of 58 caregivers representing 72.5% of the sample are children of the aged with health challenges.
- ❖ Approximately 29% are in paid formal employment, 21.2% are self-employed and 17 representing 2.2% are unemployed.
- ❖ Majority of the caregivers works for 6-7 hours per day with 37.5% earning less than 20 Ghana Cedis per day, 13.8% earn 20-30 Ghana Cedis, 35% earn 31-50 Ghana Cedis 13.7% earn from above 50 Ghana Cedis to as high as 500 Ghana Cedis.
- ❖ Taking care of the aged family member with health challenge interferes with their worship activities, of majority of the caregivers 63.8% and likewise their relationship with friends (65%).
- ❖ Approximately 86% of the caregivers do not go out for any form of entertainment as a result of the role of caregiving. Similarly majority 93.8% indicated they could not attend any form of social gathering because of the task of caregiving. Majority are able to enjoy some past time like watching movies when their aged family member is asleep.
- ❖ Majority 71.2% concluded that they don't have the best of social life as result of assuming responsibility of taking care of the aged family member.
- ❖ For those married 60% indicated the responsibility of the caregiving is affecting their marital responsibilities but for those single or divorced majority will not attribute their status to the caregiving responsibility.
- ❖ Half of the sample of caregivers surveyed (50) often fall sick as a result of their role while the other half does not. However 65.0% indicated undergoing emotional stress

or developing some form of psychological effect from the responsibility of taking care of the aged family member.

- ❖ With health status compared to before assuming the caregiving role majority 48.8% rated it as poorer, 43.8% rated it as the same. Only 7.5% rated it as better.
- ❖ Relating to families finances, 57.5% indicated more than 20% of the families financial resources are spent on the aged. Majority of 86% indicated this puts the families' coffers under pressure.
- ❖ Approximately 79% of the participants indicated other family members contribute less than 10% of the families' financial resources for the upkeep of the aged leaving the burden on the breadwinners who are mostly the children.
- ❖ Majority of the participants 78.8% do not have enough resources to discharge their care giving duties except few who have some personal investments and business.
- ❖ Generally 10-20% of families' financial resources goes into medical expenses of the aged.
- ❖ Catering for the aged family member interferes with the work of majority 75% of the caregivers who are in employment.
- ❖ Seventy-five percent of the aged were in paid employment while 23.8% were self-employed. The major sources of income are remittances 42.5%, investment 46.2%. For income per month, 60% of the aged earns between 20 to 200 Ghana Cedis, while 29 representing 36.3% earn over 200 Ghana Cedis.
- ❖ Stroke and hypertension were the major common ailments suffered by the aged followed by dementia and cancers.
- ❖ Forty percent spend above 100 Ghana Cedis monthly on treating their condition while the remaining 60% spends 100 Ghana Cedis or less.

- ❖ Feeding, medication and locomotion are the main types of care required by most of the aged with over 70% requiring 6-24 hours of care per day.



## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

The Chapter presents the summary and conclusions drawn and recommendations for the study.

#### 5.2 Summary

The study investigated the implications of health challenges of the aged on household's wellbeing in the Adentan Municipality. It specifically sought to assess the direct and indirect cost (man-hour lost) of caring for the aged with health challenges, identify the effect of the health challenges of the aged on the household social life and also to identify the effect of the health challenges of the aged on the health of the household member caregiver. Data collected from 80 caregivers with their corresponding aged family members they cater for was analyzed using descriptive tools of frequencies and percentages. The findings revealed that the aged with health challenges are mostly being cared for by their children. A total of 58 caregivers representing of the sample are children of the aged with health challenges. Majorities are in paid formal employment as compared to self-employed, and 17 representing and few unemployed.

Majority of the caregivers works for 6-7 hours per day with earning less than 20 Ghana Cedis per day, Some earn 20-30 Ghana Cedis, Others earn 31-50 Ghana Cedis while some earn from above 50 Ghana Cedis to as high as 500 Ghana Cedis. Taking care of the aged family member with health challenge interferes with their worship activities of majority of the caregivers and likewise their relationship with friends (65%). Majority of the caregivers do not go out for any form of entertainment as a result of the role of care giving. Similarly, majority

indicated they could not attend any form of social gathering because of the task of caregiving. Majority are able to enjoy some past time like watching movies when their aged family member is asleep. Majority concluded that they don't have the best of social life as a result of assuming responsibility of taking care of the aged family member.

For those married, most indicated the responsibility of the caregiving is affecting their marital responsibilities but for those single or divorced majority will not attribute their status to the care giving responsibility. Half of the sample of care givers surveyed (50) often fall sick as a result of their role while the other half does not. However most indicated undergoing emotional stress or developing some form of psychological effect from the responsibility of taking care of the aged family member. With current health status compared to before assuming the caregiving role majority rated it as poorer, as compared to those who rated it as the same; few rated it as better.

Relating to families finances, few indicated more than 20% of the families financial resources are spent on the aged. Majority of indicated this puts the families' coffers under pressure. Majority of the participants indicated other family members contribute less than 10% of the families' financial resources for the upkeep of the aged leaving the burden on the breadwinners who are mostly he children. Majority of the participants do not have enough resources to discharge their care giving duties except few who have some personal investments and business. Generally less about 10-20% of families' financial resources goes into medical expenses of the aged.

Catering for the aged family member interfere with the work of majority of the caregivers who are in employment. Seventy-five percent of the aged were in paid employment while few were self-employed. The major sources of income are remittances 42.5%, investment 46.2%. For income per month, 60% of the aged earns between 20 to 200 Ghana Cedis, while

29 caregivers earn over 200 Ghana Cedis. Stroke and hypertension were the major common ailments suffered by the aged followed by dementia and cancers. Forty percent spend above 100ghs monthly on treating their condition while the remaining spends 100 Ghana Cedis or less. Feeding, medication and locomotion are the main types of care required by most of the aged requiring 6-24 hours of care per day.

### **5.3 Conclusions**

Family caregivers are a major source of help and assistance to the elderly persons in many communities and families have long been the bedrock for long term care and all indicators suggest that they will continue to be so in the future. Caring for aged in general and more specifically those with health challenges come with a number of constraints for the wellbeing of the family. The constraints have implications for family's economy and financial resources, the social life of the family and caregivers and the health status of the caregivers. The non-availability of support from other family members due to present economic conditions and the lack of proper policy implementation from governmental agencies could be blamed for these developments. Social policy in support of family care must continue to evolve in Ghana.

Based on the findings of the study, the following conclusions can be drawn,

The aged with health challenges were mostly cared for by their children.

For the caregivers, taking care of family members with health challenges interferes with the religious activities and marital responsibilities.

Most of the respondents do not have enough financial resources to discharge their care giving duties and responsibilities.

Most of the aged were in paid employment with remittance being their source of income.

In terms of health challenges, stroke and hypertension were the major ailments suffered by the aged, followed by dementia and cancers.

## **5.4 Recommendations**

The following recommendations are made on findings of the study for policy, practice and future studies:

### **3.4.1 Recommendations for policy and practice**

Ghana needs medical personnel with specialties in geriatrics and gerontology. The Medical Council together with the government must inculcate into the training programme of medical personnel and nurses. The state and the institution in charge of social policies on the aged must implement the existing number of policies on the aged. The Social Security and National Insurance Trust (SSNIT) must make the national pension scheme cover the informal as well. Policy makers must review the health care for the aged 70 and above to cover persons aged 55 onwards.

The government must provide enabling environment for care givers to be given some form of formal training in the area of gerontological services. This would serve as a job avenue for unemployed in society. Families in need of such services will only go to such training institutions (such as care homes) to recruit professional care givers. This would give other family members in paid employment to have time for their work thereby increasing national productivity.

Every organization should have a formal programme on aging and retirement, and perceptions of the aged as a liability should be changed as well as attitude towards the aged should be changed.

The media should be encouraged to design programmes on television and radio that talk about aging and its health challenges.

The Ministry of Education must include the study of ageing in the school curriculums starting from the primary to the tertiary levels. Social support/financial aid assistants should be initiated for the extremely aged poor.

#### **5.4.2 Recommendations for future research**

- ❖ Future research should consider looking at the situation of caregiving in typical rural areas to see if the findings will be the same as urban and peri-urban communities as where the present study has been carried out.
- ❖ Large sample studies in future research to ensure external validity of findings.
- ❖ Future assessments should include not only the tangible or instrumental supports received but the elder's perception of whether their family, friends, and others are providing the desired level of emotional support.



## REFERENCES

- Aboderin, I. (2004). Decline in Material Family Support for Older People in Urban Ghana, Africa: Understanding processes and causes of change. *Journal of Gerontology*
- Aboderin, I. (2004). Modernisation theory on aging revisited: Current explanations of recent developing world and historical shifts in material family support for older people. *Ageing and Society*, 24, 29–50
- Apt, N. A. (1996). *Coping with Old Age in a Changing Africa: Social Change and the Elderly Ghanaian*. Averbury Aldeshot, Brookfield.
- Baikie, E. (2002). The Impact of Dementia on Marital Relationships. *Sexual Relationship Therapy*, 17, 28999.
- Benjamin, A. E., Matthias, R. E., Kietzman, K., & Furman, W. (2008). Retention of paid related caregivers: Who stays and who leaves home care careers"? *The Gerontologist*, 48, 104-113.
- Berquo, E. & Xenos, P. (1992). *Family Systems and Cultural Change*. Oxford University Press, New York.
- Bond, J. & Coleman, P. 1990. *Ageing in Society*. Sage Publications, London.
- Brown, C. K, (1999) Care of the Elderly: Perspectives from Ghana and Japan. Catholic Mission Press, Cape Coast
- Buhr G. T., Kuchibhatia M., Clipp E. (2008). Caregivers' reasons for nursing home placement: cues for improving discussions with families prior to the transition. *Gerontologist* 46 52–61.
- Cameron, K. A, Song, J, Manheim, L.M, & Dunlop, D. D. (2010). Gender disparities in health and healthcare use among older adults. *Journal of Womens Health (Larchmt)*, 19(9):1643-1650.

- Cantor, M. & Little, V. (1985). *Aging and social care*. In R. H. Binstock & E. Shanas (Eds.), *Handbook of aging and the social sciences* (pp. 745-781). New York: Van Nostrand Reinhold.
- Case, A & Deaton, T. (2001). “Does Money Protect Health Status? Evidence from South African Pensions.” Discussion paper at National Bureau of Economic Research
- Center on Aging Society. (2009). *How Do Family Caregivers Fare? A Closer Look at Their Experiences*. (Data Profile, Number 3). Washington, DC: Georgetown University
- Chappell, N. L., & Reid, R. C. (2002), “Burden and well-being among caregivers: Examining the distinction”. *The Gerontologist*, 42(6), 772-780.
- Chorn-Dunham, C., & Dietz, B. E. (2003), “If I’m not allowed to put my family first: Challenges experienced by women who are caregiving for family members with dementia”. *Journal of Women and Aging*, 15(1), 55–70.
- Cowgill, D. O. (1986). *Aging Around the World*. Wadsworth Publishers. Belmont, CA. *Daily Graphic*, 2003. “Aged to be Granted Exemption Under NHIS”. *Daily Graphic* Newspaper, Monday, February 10, Front Page.
- Cowgill, D. O. 1986. *Aging Around the World*. Wadsworth Publishers. Belmont, CA.
- Cox, F. M. and N. U. Mberia (2007). *Aging in a Changing Society: A Kenyan Experience*. New York: International Federation on Aging.
- Daily Graphic, 2003. “Aged to be Granted Exemption Under NHIS”. *Daily Graphic* Newspaper, Monday, February 10, Front Page.
- Degeneffe, C. E. (2001). Family Caregiving and Traumatic Brain Injury. *Health & Social Work*, 26(4),257268.

- Department of Social Development. 2002a. "National Report on the Status of Older Persons: Report to the Second World Assembly on Ageing." Discussion paper
- Dettinger, E. & Clarkberg, M. (2002), "Informal caregiving and retirement timing among men and women: Gender and caregiving relationships in late midlife". *Journal of Family Issues*, 23 (7), 857–879.
- Dooche, G. (1994). *Social aspects of aging*. In G. J. Stolnitz (Ed.), *Social aspects and country reviews of population aging: Europe and North America* (pp. 9-36). Geneva: United Nations.
- Doty, P., Mahoney, K. J., Simon-Rusinowitz, L., Sciegaj, M., Selkow, I., & Dawn M. Loughlin, D. M. (2012), "How Does Cash and Counseling Affect the Growth of Participant-Directed Services"? *Generations*, 36 (1), 28–36.
- Dwyer, J. W., & Coward, R. T. (1991). A multivariate comparison of the involvement of adult sons versus daughters in the care of impaired parents. *Journal of Gerontology*, 46, S259-269.
- Dykstra, P. A. (1993). The differential availability of relationships and the provision and effectiveness of support to older adults. *Journal of Social and Personal Relationships*, 10, 355-370.
- Dykstra, P. A., & Knipscheer, C. P. M. (1995). The availability and intergenerational structure of family relationships. In C. P. M. Knipscheer, J. de Jong Gierveld, T. Van Tilburg, & P. A. Dykstra (Eds.), *Living arrangements and social networks of older adults* (pp. 37-58). Amsterdam: VU University Press.
- Economist Intelligence Unit 2009. Healthcare strategies for an ageing society, the fourth report.

- Family Caregiver Alliance. (2008). *Caregiver Assessment: Principles, Guidelines and Strategies for Change*. Report from a National Consensus Development Conference (Vol. I) San Francisco: Author
- Finch, J., & Mason, J. (1990). Filial obligations and kin support for elderly people. *Aging and Society, 10*, 151-175.
- Foster, L., Brown, R., Phillips, B., & Carlson, L. B. (2003), *Easing the burden of caregiving: The impact of consumer direction on primary informal caregivers in Arkansas* [Final report]. Princeton, NJ: Mathematica Policy Research.
- Foster, L., Brown, R., Phillips, B., & Carlson, L. B. (2003), *Easing the burden of caregiving: The impact of consumer direction on primary informal caregivers in Arkansas* [Final report]. Princeton, NJ: Mathematica Policy Research. Available online at [www.ncbi.nlm.nih.gov/pubmed/16051910](http://www.ncbi.nlm.nih.gov/pubmed/16051910)
- Friedland, R. & Lewis, S. (2004), *Choosing a long-term care insurance policy: understanding and improving the process*. Center on an Aging Society Health Policy Institute Georgetown University.
- Gan, C. & Schuller, R. (2002). Family system outcome following acquired brain injury: Clinical & research perspectives. *Brain Injury, 4*, 311-322
- Gerstel, N. & McGonagle, K., (2002). Job leaves and the limits of the family & medical leave act: The effects of gender, race & family. In: Dubeck, P. J. & Dunn, D. (Eds.). *Workplace/Women's Place: An Anthology*.(pp. 205-215). Los Angeles: Roxbury Publishing Company.
- Ghana Statistical Service (GLSS), 2002. 2000 Population and Housing Census: Summary Report of Final Results. The GSS, Accra.
- Ghana Statistical Service (GSS), 2002. *2000 Population and Housing Census: Summary Report of Final Results*. The GSS, Accra.

- Gilligan, C. (1982). *In a Different Voice: Psychological Theory & Women's Development*. Cambridge, MA: Harvard University Press.
- Goldzweig, G., Merims, S., Ganon, R., Peretz, T., Altman, A. & Baider, L. (2013) Informal caregiving to older cancer patients: Preliminary research outcomes and implications. *Annals of Oncology* 24:2635-2640, 2013 doi:10.1093/annonc/mdt250.  
Downloaded from <http://annonc.oxfordjournals.org/> (assessed on 23/09/2016)
- Goode, W. J. (1963). *World Revolution and Family Patterns*. Free Press of Glencoe. New York.
- Hagestad, G. O. (1987). Able elderly in the family contact: Changes, chances, and challenges. *Gerontologist*, 27,417-428.
- Hanson, S. M., & Sauer, W. J. (1985). Children and their elderly parents. In W. J. Sauer & R. T. Coward (Eds.), *Social support networks and the care of the elderly* (pp. 41-66). New York Springer.
- Heru, A. M., Ryan, C.E. & Iqbal, A. (2004). Family functioning in the caregivers of patients with dementia. *International Journal of Geriatric Psychiatry*, 19, 533-537.
- Hess, B. B., & Waring, J. M. (1978). Changing patterns of aging and family bonds in later life. *Family Coordinator*, 27, 303-314.
- Hogan, V., Lisy, E. D., Savannah, R.L., Henry, L., Kuo, F. & Fisher, G.S. (2003). Role change experienced by family caregivers of adults with Alzheimer's disease: Implications for Occupational Therapy. *Physical & Occupational Therapy in Geriatrics*, 22(1), 21-43.
- Hooyman, N. R., & Kiyak, H. A. (Eds.) (1988). *Social Gerontology-A multi-disciplinary perspective*. Boston: Allyn & Bacon.

- Horowitz, A. (1985). Family caregiving to the frail elderly. In M. P. Lawton & G. Maddox (Eds.), *Annual Review of Gerontology and Geriatrics* (pp194-246). New York: Springer.
- Hsu, S.W, Lin, J.D, Chiang, P.H, Chang, Y.C, & Tung, H.J. (2012). Comparison of outpatient services between elderly people with intellectual disabilities and the general elderly population in Taiwan. *Res Dev Disabil*, 33(5):1429-1436
- Hughes RG (ed.). *In Patient safety and quality: An evidence-based handbook for nurses.*(Chapt 14), AHRQ Publication No. 08-0043. Rockville, MD: Agency for Healthcare Research and Quality Available at [www.ahrq.gov/qual/nurseshdbk/nurseshdbk.pdf](http://www.ahrq.gov/qual/nurseshdbk/nurseshdbk.pdf)
- Institute of Medicine Report [IOM]. (2009). *Building the Health Care Force*. Washington, DC: National Academies Press
- Johnson, C. L., & Catalano, D. J. (1983). A longitudinal study of family supports to impaired elderly. *The Gerontologist*, 23, 612-618.
- Keefe, J., Fancey, P., & S. White. (2005), Consultation on Financial Compensation Initiatives for Family Caregivers of Dependent Adults. Final report. Halifax (NS): Mount Saint Vincent University.
- Keefe, J. & Rajnovich, B. (2007), "To pay or not to pay: Examining underlying principles in the debate on financial support for family caregivers". *Canadian Journal on Aging*, 26 (suppl 1), 77 – 90.
- Knipscheer, C. P. M. (1980). *Old people and their social context*. The Hague: UUGA-Publishers
- Lee, G. R., Dwyer, J. W., & Coward, R. T. (1993). Gender differences in parent care: Demographic factors and same-gender preferences. *Journal of Gerontology*, 48, 59-516.

- Litwak, E., & Kulis, S. (1987). Technology, proximity, and measures of kin support. *Journal of Marriage and the Family*, 49, 649-661.
- Mack, K. (2005), *How do family caregivers fare? Data Profile*, Number 3. Center on an Aging Society, Georgetown University. Available at <http://ihcrp.georgetown.edu/agingsociety/pdfs/CAREGIVERS3.pdf>
- Mba, C J. (2006). The Health Condition of Older Women in Ghana: A Case Study of Accra City. *Journal of International Women's Studies*, 8(1), 171-184.
- Mba, C. J. (2004b). "Older Persons of Ghana", *Quarterly Journal of the International Institute on Ageing*, 15, (1) pp. 14-18.
- Mba, C. J. 2004a. "Population Ageing and Survival Challenges in Rural Ghana" in *Journal of Social Development in Africa*, Vol. 19, No.2, 2004, pp. 90-112.
- Meijer Cde, Wouterse B, Polder J, Koopmanschap M 2013. The effect of population aging on health expenditure growth: a critical review. *Eur J Ageing*, 10:353–361.
- Miller, B. (1990). Gender differences in spouse caregiving strain: Socialization & role explanations. *Journal of Marriage & the Family*, 52, 311-321.
- Modernization Theory on Ageing-available at [www.enotes.com/research-starters/ageing-theory-modernization-theory](http://www.enotes.com/research-starters/ageing-theory-modernization-theory) (assessed on 20/09/2016)
- Moore, G. (1990). Structural determinants of men's and women's personal networks. *American Sociological Review*, 55, 726-735.
- National Alliance for Caregiving (NAC), and AARP. (1997, 2004, 2008, 2009, 2012). *Caregiving in the U.S.* Washington, DC
- Navaie-Waliser M., Feldman P. H., Gould D. A., Levine C. L., Kuerbis A. N., Donelan K. (2004). When the caregiver needs care: the plight of vulnerable caregivers. *Am. J. Public Health* 92 409–413 10.2105/AJPH.92.3.409 [[PMC free article](#)] [[PubMed](#)] [[Cross Ref](#)]

- Nie JX, Wang L, Tracy CS, Moineddin R, Upshur RE (2008). Health care service utilization among the elderly: findings from the Study to Understand the Chronic Condition Experience of the Elderly and the Disabled (SUCCEED project). *J Eval Clin Pract*,14(6):1044-1049.
- Nie JX, Wang L, Tracy CS, Moineddin R, Upshur RE 2010. A population-based cohort study of ambulatory care service utilization among older adults. *J Eval Clin Pract*, 16(4): 825-831.
- Nixon, D. C. (2008), Tax Incentives for Family Caregivers: A Cost-Benefit Analysis. Available at [www.publicpolicycenter.hawaii.edu/documents/paper003.pdf](http://www.publicpolicycenter.hawaii.edu/documents/paper003.pdf)
- Okoye, U. O. (2012), “Family caregiving for ageing parents in Nigeria: gender differences, cultural imperatives and the role of education”. *International Journal of Education and Ageing*, 2 (2), 139–154.
- Pearlin, L. I., Pioli, M. F., & McLaughlin, A. E. (2001), “Caregiving by adult children: Involvement, role disruption, and health”. In R. H. Binstock & L. George (Eds.), *Handbook of aging and the social sciences* (5<sup>th</sup> ed., pp. 238-253). San Diego, CA: Academic Press.
- Penning, M. J. (1990). Receipt of assistance by elderly people: Hierarchical selection and task specificity. *The Gerontologist*, 30, 220-227.
- Penning, M. J., & Strain, L. A. (1994). Gender differences in disability, assistance, and subjective well-being in later life. *Journals of Gerontology: Social Sciences*, 49, S202-S208.
- Pezzin, L.E.,Kemper,P.,&Reschovsky,J.(1996).Doespubliclyprovidedhomecaresubstitute for family care? Experimental evidence with endogenous living arrangements. *Journal of Human Resources*, 31, 650-676.

- Pinquart M., Sorenson S. (2003). Differences between caregivers and non-caregivers in psychological health and physical health: a meta-analysis. *Psychol. Aging* 18 250–267 10.1037/0882-7974.18.2.250 [PubMed] [Cross Ref]
- Reinhard, S. C., Given, B., Huhtula, N., & Bemis, A. (2008), *Patient safety and Quality: An evidence-based handbook for Nurses*. “Supporting family caregivers in providing care”. Rockville (MD): Agency for health care research and quality (US), Chapter 14. [www.ncbi.nlm.nih.gov/books/NBK2665/?report=printable](http://www.ncbi.nlm.nih.gov/books/NBK2665/?report=printable) (assessed on 23/09/2016)
- San Antonio, P. M., Eckert, J. E. & Simon-Rusinowitz, L. (2006), “The importance of relationship: elders and their paid family caregivers in the Arkansas cash and counseling qualitative study”. *The Journal of Applied Gerontology*, 25,(1) 31-48. DOI: 10.1177/0733464805282537.
- Schulz, R., & Quittner, A. (1998), “Caregiving for children and adults with chronic conditions: Introduction to the special issue”. *Health Psychology*, 17(2), 107-111
- Schwartz, A. E. (2002), “Societal value and the funding of kinship care source”. *Social Service Review*, 76 (3), 430-459.
- Shanas,E.(1979).Thefamilyasupportsysteminoldage.*TheGerontologist*,19,169-174
- Silverstein, M. & Parrott, T.M. (2001), “Attitudes towards government policies that assist informal caregivers”. *Research on Aging*, 23, 349-374.
- Smith B. D., Smith G. L., Hurria A., Hortobagy G. N., Bucholz T. A. (2009). Future of cancer incidence in US: burdens upon an aging population. *J. Clin. Oncol.* 27 2758–2765 10.1200/JCO.2008.20.8983 [PubMed] [Cross Ref]

- Spillman B. C, & Pezzin L. E. (2000), "Potential and active family caregivers: Changing networks and the "sandwich generation." *Milbank Memorial Fund Quarterly*, 78, 347-74.
- Suitor, J. J. & Pillemer, K. (1994). Family caregiving & marital satisfaction: Findings from a 1-year panel study of women caring for parents with dementia. *Journal of Marriage & the Family*, 56, 681-90.
- Suitor, J. J., Pillemer, K., Keeton, S., & Robison, J. (1995). *Aged parents and aging children: Determinants of relationship quality*. In R. Blieszner & V. Hilkevitch Bedford (Eds.), *Handbook of aging and the family* (pp. 223-242). Westport: Greenwood Press.
- Tennstedt, S.L., Crawford, S., & McKinlay, J.B. (1993). Determining the pattern of community care: Is co-residence more important than caregiver relationship? *Journal of Gerontology*, 48, S74-S83.
- Troll, L. E. (1987). Gender differences in cross-generation networks. *Sex Roles*, 17, 751-766.
- Van Der Geest, S. (2002). Respect and Reciprocity: Care of elderly people in Rural Ghana. *Journal of cross-cultural Gerontology*, Vol. 17 Issue 1, pp 3-31
- Woo, J., Goggins, W., Zhang, X., Griffiths, S, & Wong, V. (2010). Aging and utilization of hospital services in Hong Kong: retrospective cohort study. *Int J Public Health*, 55(3):201-207.
- World Health Organization. Interesting facts about ageing.  
<http://www.who.int/ageing/about/facts/en/index.html>. Accessed 1 January 2014.
- World Population Prospects [WPP]. (2011). *The 2010 Revision, Highlights and Advance Tables*. Working Paper No. ESA/P/WP.220 Department of Economic and Social Affairs, Population Division New York, NY

Zarit, S. H., Johansson, B., & Berg, S. (1993). Functional impairment and co-disability in the oldest old. *Journal of Aging and Health, 5*, 291-305.

Zarit, S. H., Johansson, B., & Malmberg, B. (1995). Changes in functional competency in the oldest old. *Journal of Aging and Health, 7*, 3-23.

