Journal of Poverty, Investment and Development
ISSN 2422-846X An International Peer-reviewed Journal
Vol.6, 2014

Socio-Economic and Health Experiences of the Aged in Rural Ghana: The Case of Charia in the Wa Municipal Area

James Daare Saaka B.A. (HONS) [Corresponding Author]
Department of Geography and Rural Development
Kwame Nkrumah University of Science and Technology, Kumasi-Ghana
Email: daarejames_saaka@yahoo.com

Francis Xavier Naab (MSc.)
Department of Planning, Kwame Nkrumah University of Science and Technology, Kumasi-Ghana
Email: francisnaab@yahoo.com

Eva Tagoe-Darko (Ph.D.)
Department of Geography and Rural Development
Kwame Nkrumah University of Science and Technology, Kumasi-Ghana
Email: motabla@hotmail.com

Abstract
The 21st century has witnessed a tremendous increase of the elderly population in developing countries. However, old age is polarized with numerous challenges that cannot be investigated in a single study. The principal objective of this was to investigate the socio-economic and health experiences of the aged in rural Ghana, using Charia as a case study. Data were from a total of old men and women from Charia as well as some key informant interviews. The tools that were used for data collection include structured interview schedules, questionnaires, face-to-face interviews checklists and Focus Group Discussions guides. Quantitative data was analyzed using Statistical Product for Service Solution (SPSS) and Microsoft Excel and have been presented in the form of charts and tables. The chi-square test of independence was used to test hypotheses that were made in the study at 5% level of significance. Direct quotations from transcribed data have been used in analyzing qualitative data. Findings from this study revealed that old women were more vulnerable to the challenges of old age than old men. Subsequently, opinions of the aged were not respected and their financial conditions were found to be appalling. Furthermore, most of the elderly people in Charia seldom visit the hospital when they are sick, and finally but most importantly, there was no any form of support scheme for the aged in Charia. It is recommended that serious attention is given to the implementation of the Livelihood Empowerment Against Poverty (LEAP) programme to support the finances of the aged. Also, families are encouraged to support the aged to visit health care centres and finally, the youth are encourage to make Proper care and respect for the aged a culture so as to be respected and be supported at old age.
Keywords: Socio-economic, Health experiences, aged, Charia and Ghana

1. Introduction and background

Demographic transition is being manifested throughout the world in recent times (Crampton, 2009). The transition is in favour of the aged as ageing population becomes a common feature among the populations of many countries, both developed and developing (Tawiah, 2011; Kwankye, 2013). Worth noting of ageing population is the recognition that it is not uniform across the globe. Currently, 20% of the population in developed countries is above 60 years whiles in the developing countries, the percentage of the aged (60 years and above) is less than 10% (Kwankye, 2013).

Nevertheless, the proportion of older persons in developing countries is projected to double by 2050 with the elderly population hitting 20 percent (Kwankye, 2013). Population ageing on the other hand refers to an increase in the proportion of the elderly in the total population of any nation (GSS, 2005; Tawiah, 2011; GSS, 2013a). The 21st century has witnessed a tremendous increase of the elderly population in developing countries. The elderly population almost quadrupled from 67 million in 1950 to 250 million in 2000, a percentage increase of 3.73 as against 2.67 for the developed countries (GSS, 2013a; Kwankye, 2013).

The United Nations uses the 60 year age ceiling to refer to the aged. In the developed world where life expectancy is high, the retirement age is put at 65, classifying the aged to be those who attain the age of 65.

In the developing world however, the retirement age is put at 60 years due to a comparatively shorter life expectancy. In this case, the aged encompasses those who attain 60 years and above (GSS, 2013a). Article 2 of the Madrid International Plan of Action on Ageing forecast the demographic transition in favour of the aged when it states;

> *We celebrate rising life expectancy in many regions of the world as one of humanity's major achievements. We recognize that the world is experiencing an unprecedented demographic transformation and that by 2050 the number of persons aged 60 years and over will increase from 600 million to almost 2 billion and that the proportion of persons aged 60 years and over is expected to double from 10 to 21 per cent. The increase will be greatest in developing countries where the older population is expected to quadruple during the next 50 years. This demographic transformation challenges all our societies to promote increased opportunities, in particular opportunities for older persons to realize their potentials to participate fully in all aspect of life (United Nations, 2002:1).*

Population ageing is a by-product of mankind's triumph over deadly diseases which previously devastated humanity. This consequently ensured a prolonged life span from birth. Decline in fertility as a results of attitudinal change and high rate of child survival has also contributed to the increase in the proportion of older persons. Improvement in nutrition and general increase in standard of living means that people will grow older and thus increasing the numbers and proportions of senior citizens in all populations (Apt, n.d.; GSS 2005; Tawiah, 2011; GSS, 2013a; Kwankye, 2013; Ocansey et al., 2013; Ba-Ama and YaabaAckah, 2014)

Although Africa's population is being described as young due to the high proportion of the under 15 year group (about 40%), the elderly proportion on the other also increases steadily. According to kwankye (2013), Africa recorded 3.6% of its population being 65 years and above, an increase from 3.3% within 10 years in 2010.

Ghana's population can be described as youthful (Tawiah, 2011; GSS, 2013a; GSS, 2013b). Records show that the under 15 year group made up of 44% in 1960, 46.9% in 1970, 45% in 1984, 41.3% in 2000 and 38.3% in 2010. It is imperative however to note that the proportion of the aged is increasing in Ghana. For the 65 years and above, the trend shows an increase from 3.2% in 1960 to 3.6% in 1970, 4.0% in 1984, 5.3% in 2000 and decreased to 4.7% in 2010 (GSS, 2013a; Kwankye, 2013).

Kwankye's (2013) findings on Ghana's demographic characteristics reaffirm an increase in the proportion of the elderly in the Ghanaian population. It is also an attestation that population ageing is caused by a decline in fertility and an increase in life expectancy. Life expectancy has been increasing steadily in Ghana from 45.5 years in 1960 to 48.6 in 1970, stood at 58 years in 2003 and is reported to increase to 60.7 years for males and 61.8 years for females in 2010 (kwankye, 2013).

1.1 Challenges of Population Ageing

Ageing, though a natural phenomenon is a period of infirmity and the aged for that matter, needs to be supported in order to participate in their normal day-to-day activities (National Council on Population and Ageing, 2005; Mba, n.d.). Population ageing, which is one of humanity's greatest achievements, is polarized with a catalogue of challenges. These challenges range from the increasing need for social support by the aged (Apt, n.d.; Beard and Petitot, n.d.; United Nations, 2002; GSS, 2005; Tawiah, 2011; GSS, 2013a; Kwankye, 2013; Ba-Ama and YaabaAckah, 2014), health problems (Ghana Country Report, 2007; Kwankye, 2013; GSS, 2013a; Ocansey et al., 2013) and economic hardships among the aged (Mba, n.d.; Tawiah, 2011; GSS, 2013a; Kwankye, 2013). These challenges though a global issue, the plight of the aged is greater in the developing countries (Tawiah, 2011)

1.1.1 Old age and Health Challenges

Physiologically, ageing reduces the ability of the body to fight diseases. Due to the inability to fight diseases, old age is associated with a toll of health problems (Aboderin, n.d.; Tawiah, 2011; Ocansey et al., 2013). The infirmity associated with old age according to Ocansey et al (2013) will imply an increasing demand for care at old age. Visual impairment in particular is an age-related problem and is caused by cataract, glaucoma, macular degeneration, diabetic retinopathy and corneal opacity which are all age-related diseases. The United Nations at the Madrid International Plan of Action on the Aged recognized the health needs of older persons. Pursuance of the health needs of the aged is the statement under article 14 that;

> We commit ourselves to providing older persons with universal and equal access to health care and services, and we recognize that the growing needs of an ageing population require additional policies, in particular care and treatment, the promotion of healthy lifestyles and supportive environment (United Nations, 2002:3-4).

Acknowledging the numerous health needs of the aged is the Ghana government's intervention to exempt older adults aged 70 and above from the payment of premium under the National Health Insurance Scheme (Tawiah, 2011).

Hypothesis

H_0: Health challenges of the aged in Charia are not age related

H_1: Health challenges of the aged in Charia are age related

1.1.2 Old age and Social Challenges

One of the major experiences in old age is social deprivation. Tawiah (2011), in a study noted that the elderly in Ghana especially women, are most often than not tagged with witchcraft. The elderly are usually dehumanized and undergo violence of various kinds within the societies in which they find themselves. They are simply not respected, and in most cases made to lose their dignity (Tawiah, 2011). Of particular concern is the fact that older persons need support from the family and society at large. This notwithstanding, the traditional system of support and respect that older persons enjoyed in the family and within society is gradually becoming a thing of the past (Ozsen and Takuno, 2008; Crampton, 2009; Niles, 2010; Tawiah, 2011; GSS, 2013a; Kwankye, 2013) due to the breakdown in the hitherto extended family system (Ba-Ama and YaabaAckah, 2014).

It is rather unfortunate that the main if not the only social protection scheme in Ghana is the national insurance scheme administered by the Social Security and National Insurance Trust (SSNIT). This inadequate scheme is however in favour of retired public workers (Karlberg, 2007; Tawiah, 2011), yet statistics show that majority of the aged in Ghana are found in rural settings who usually do not benefit from this scheme (GSS, 2013a; Kwankye, 2013). The Ghana Statistical Service (2013a) noted that social exclusion and loneliness are among the major social problems among the aged

1.1.3 Old age and Economic Challenges

It is not uncommon for people to raise questions concerning the contribution of the aged to the economy of their nations. The intent, of most studies most often than not is to evaluate the contribution of older people to the economic development of their countries (Butterfill, 2003; Kwankye, 2013). This has brought to the fore the issue of the economic status of older people's private lives especially those residing in rural areas. Economic security of the aged in the rural areas is worthy of examining since unlike their urban counterparts, they often do not have any form of reliable pensions and savings to safeguard their old age. It is also an indication that the aged need to be supported economically since they still have to meet some economic needs. Income levels of the aged are reduced drastically likewise their savings. This situation is even worst in most rural areas in Ghana where Charia, the study community is not an exception. Some older people will inevitably have to reduce their farm sizes which will not only reduce output; it will also affect their income levels. Less output will mean that less will be available to serve as food and as marketable surplus at the time which will ultimately affect their general economic conditions. In the work of Kwankye (2013), income levels of older persons are very low in Ghana. This viewpoint is not significantly different from what is being expressed in this study. The extent to which this low income levels in the rural areas affect the economic needs of the aged in Charia, the study community is an issue that is to be addressed in this study.

The elderly in Ghana have experienced the challenges of old age. It is realized that majority of the aged who live in the periphery, according to Dziechciaz et al (2012), wallow in numerous challenges including health, social, financial and organizational issues. The elderly are the best people to reveal their own life problems as it is often said, "Experience is the best teacher". Having tasted their youthful exuberant stage and current infirm stage of life, this study will want to explore the lived experiences of the aged bearing in mind their social, economic and health needs.

A framework on the effect of poor health, poor socio-economic conditions, lack of participation and insecurity on the aged

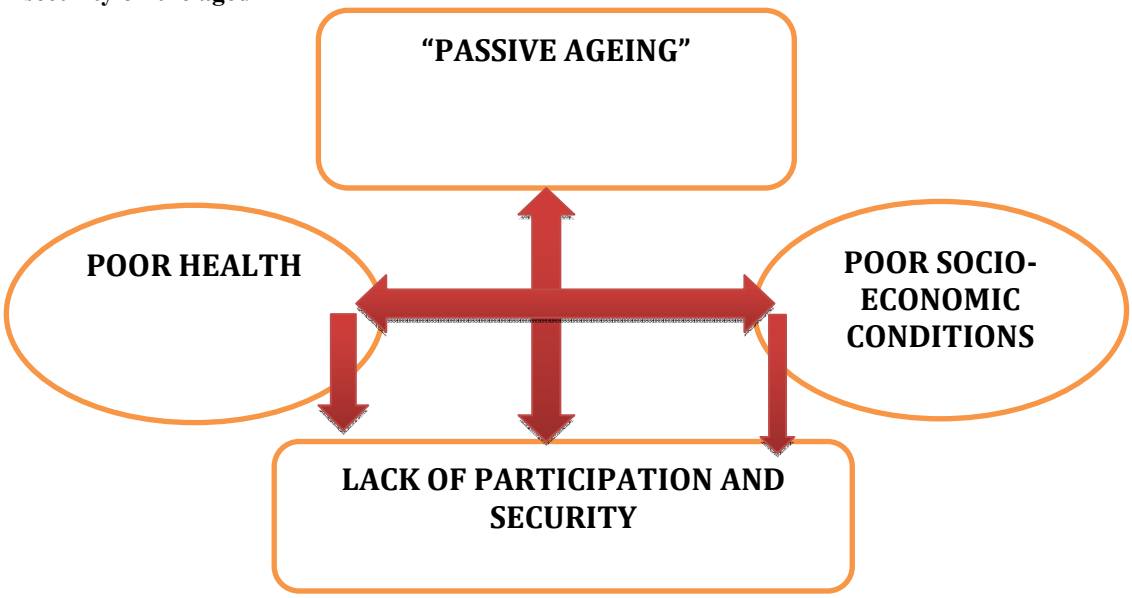


Figure 1: *Active Ageing: a Policy Framework. Source: Adapted from (WHO, 2002:45).*

Population ageing is one of humanity's greatest achievement and would have being more joyful if prolonged lives were accompanied by good health, sound socio-economic conditions, participation and proper security. The process of achieving these is referred to as "active ageing" (WHO, 2002). Subsequently, poor health at old age, poor socio-economic conditions, lack of participation and insecurity would result into incapacitated life style at old age which would be referred to as "passive ageing" in this study.

This framework seeks to explain the effect of poor health, poor socio-economic conditions, lack of participation and insecurity on life style at ole age, thus "passive ageing". The suggestion of the framework is that poor health at old age would lead to poor socio-economic conditions. In a similar manner, poor socio-economic conditions would also have a debilitating effect on the health of people as they grow old. The cumulative effect of poor health and poor socio-economic conditions would be lack of participation and insecurity within one's society.

As people are unsecured and cannot participate at their older ages, they are compelled to lead a passive life style in society. In effect, poor health leads to poor socio-economic conditions and the vice versa. On the other hand, these two blocks of the framework, thus poor health and poor socio-economic conditions lead to lack of participation and insecurity at old age culminating into "passive ageing"

1.2 Research questions

As a matter of fact, the state of the aged serves as a source of worry to all concern persons. In order to clear some of the confusions about the aged and their socio-economic and health experiences, the following questions need to be answered.

- Are there any changes in the health experiences of the aged as the result of their old age?
- What are the social experiences of the aged?
- What are the economic experiences of the elderly in Charia?

1.2.1 Research Objectives

The main objective of this study is to examine the socio-economic and health experiences of older citizens, while the specific objectives shall be as follows:

- To examine the health experiences of the aged in Charia.
- To find out the social challenges experienced by the aged in Charia.
- To determine the economic experiences of the aged in Charia.

1.3 Study Methodology

1.3.1 Overview of Study Area

This study was conducted in Charia, a rural community within the Wa Municipal area. The Wa Municipality, the only municipality out of the eleven municipal and district assemblies lies within latitude 9^{o} 32′ N to 10^{o} 20′ N and longitude 1^{o} 40′ W to 2^{o} 45′ W. The Wa Municipal Assembly shares boundaries to the north with the Daffiama, Bussie, Issa District. To the east, it is bordered with the Wa East District and the Wa West District to the west where the study community, Charia served as one of the border communities between the Wa Municipal Area and the Wa West District as shown in Figure 2.1. Its southern border is shared with the Tuna- Kalba District in the Northern Region (Wa Municipal Assembly, 2010).

According to the 2010 population and housing census, the Upper West Region has a total population of 702,110 (GSS, 2013b). Out of this number, the elderly population constitutes 3.6% which is lower than the national elderly population of 4.7% for the age 65 and above group (GSS, 2013a). However, the Wa Municipal Assembly projected the elderly population at 4.3% (Wa Municipal Assembly, 2010) a little below that of the total country. The Wa Naah is the overall paramount chief of the Wa Municipality, followed by other Divisional Chiefs including the chief of Charia. The Wa Municipal area is dominated by agriculture as the major economic activity. About 86 percent of the populations in the assembly engage in agricultural activities which is usually heavily dependent on rain water which is also erratic for successful crop production. There are however, other economic activities within the assembly including small-scale industry and commerce. The Wa Municipality is the commercial center of the assembly where trading is mostly carried out at the Wa central market (Wa Municipal Assembly, 2010)

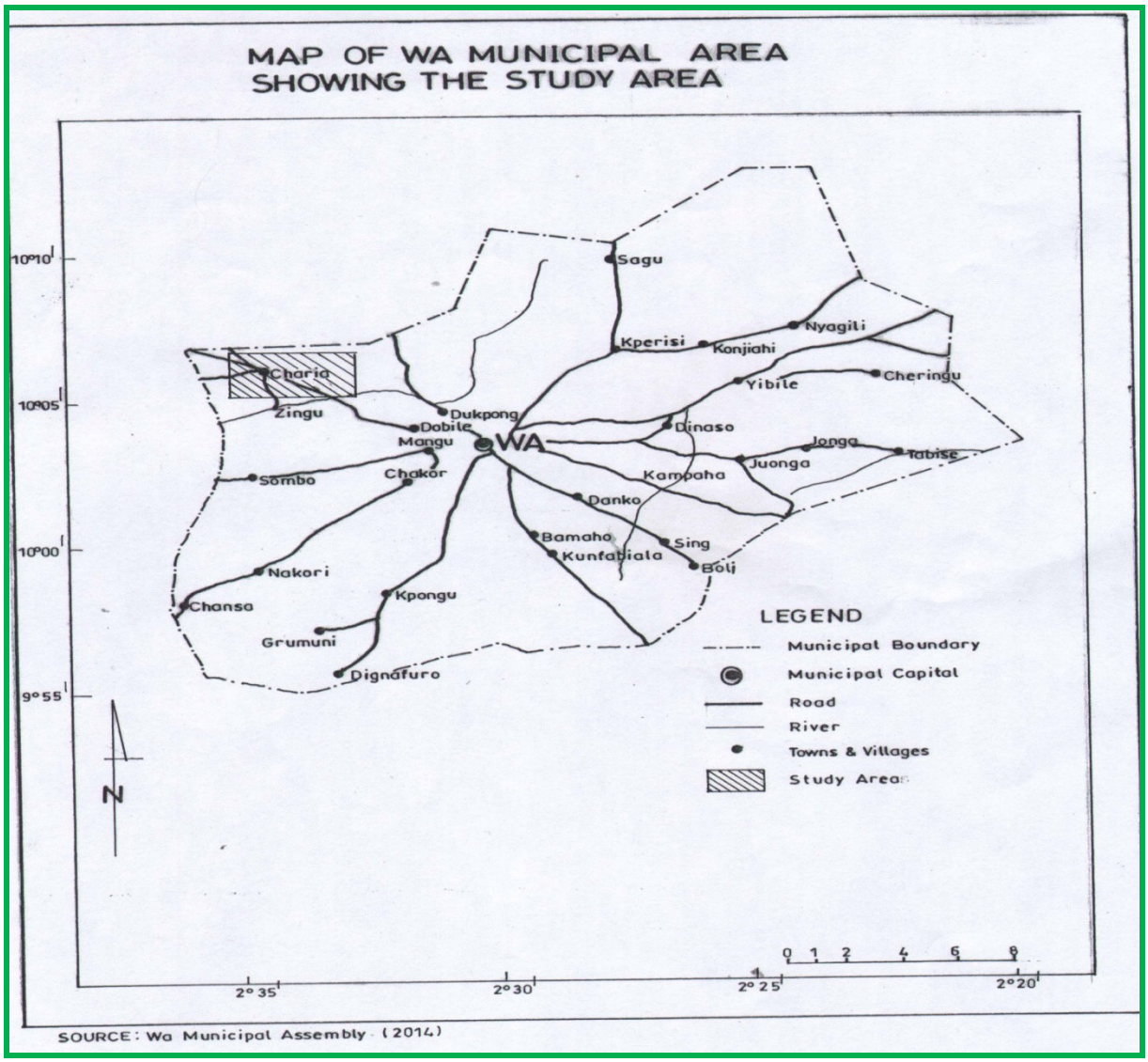


Figure 2: Location of Charia (the study area) within the Wa Municipal Assembly
***Source**: Wa Municipal Assembly (2014)*

1.3.2 Data Collection and Analysis

This study was conducted using both qualitative and quantitative research designs. This mixed method design was deemed appropriate for this study due to its inherent ability to explain complexities in the socio-economic and health experiences of the aged in a rural area; through concurrent triangulation which allow for confirmation, disconfirmation, validation and corroboration of data (Creswell, 2009).

Both primary and secondary sources of data were utilized to obtain the primary and secondary data for the study. A combination of the two sources of data presented an opportunity to confirm some related issues discovered in the in the literature review.

Primary data were collected through Focus Group Discussions (FGDs). Four (4) FGDs were conducted consisting of old men only, old women only, men only and women only groups. The procedure was considered appropriate as it revealed ideas concerning the socio-economic and health experiences of the aged bearing in mind the cultural issues that could interfere with free communication among both men and women in the Charia community.

In this study, the aged were grouped under two categories, thus the "young old" (age 60 to 74) and the "old old" (75 years and above). Structured interview guides, questionnaires and FGDs guides were used to gather primary data from the "young old". The reason for is that members of this age group were still active so their inclusion brought diversity into the responses. Consequently, the "young old" were considered to take part of the focus group discussions and also in questionnaire administration. The structured interview questionnaires were also able to provide uniform data that will allow for quantitative analysis.

In-depth interviews and conversations were utilized to gather data from the "old old" since this age

group most often than not were incapacitated in diverse ways including mental malfunctioning leading to forgetfulness. It was therefore be difficult to engage them in focus group discussions and other tools such as structured questionnaires. Conversations and in-depth interviews were considered appropriate due to the fact that they gave them the opportunity to give an account of their experiences in totality which was later transcribed by the researchers and scrutinized for the most useful information relating to the study.

In order to ensure transcription quality and trustworthiness, pretesting of were done before the actual recording process during the FGDs. Again, multiple gadgets were used to increase the reliability of the information that was recorded. Structured interview questionnaires were also used in obtaining the primary data. This was necessary because most of the respondents could not read and write. Unstructured In-depth interviews were conducted among personnel of Wa Social Welfare and the Charia Health Center to obtain primary data on the aged.

Secondary data were collected from both published and non-published documents such as books, articles and journal. These were obtained from libraries, the internet among others.

In this paper, data were collected from the Aged (60+) group in the Charia Community which is the study community, the Charia Health Center and the Wa Social Welfare. Additionally, Herbalists, Spiritualists and Traditional Healer were contacted using in-depth interviews to gather information about the socio-economic and health experiences of the aged.

The sampling techniques that were utilized in this study included both simple random and purposive sampling techniques. The preference of the simple random sampling method was based on the fact that it gave every old person in the Charia community an equal chance of being selected hence reducing the source of bias in the sample. The purposive sampling method on the other hand was considered appropriate since some key informants such as Herbalists, Traditional Healers, Officials of the Charia Health Centre and Workers of the Wa Social Welfare constituted a group of individuals who specialized in their fields and know-how could have a bearing on this study but were not heterogeneous in the study community. The 2010 Population and Housing Census reveal that Charia had a total population of 2,825 (GSS, 2013a). A total of one hundred and fifty (150) old men and women were randomly selected for the purpose of empirical observation. The key informants on the other hand were selected purposively for data administration.

Qualitative data collected through Focus Group Discussions were transcribed and supported by some direct citations from respondents. On the other hand, quantitative data were analyzed using statistical software (SPSS (version 20) and Microsoft Excel) to establish cross tabulations and descriptive statistics parameters.
The chi-square test of independence was used to test the hypotheses made in this study about old age and health status at 5% level of significance.

1.4 Results

The aged in this study were categorized into two groups: those who were 60 years to 74 years (the “young old”) and those who were 75 years and above (the “old old”). The evidence of increasing mortality as one grows older is being manifested in this study. The analyses revealed that 66.7% of the sample were those who attained the ages of 60 to 74 years while those who attained over 75 years constituted 33.3%. Obviously, as one grows older the risk of dying increases explaining why the “young old” formed the greater proportion of the sample.

The areas of concentration throughout the analyses included the demographic information of respondents, social, economic as well as health experiences of the aged of Charia.

1.4.1 Demographic characteristics of the aged of Charia

Table 1. Demographic Characteristics of the Aged of Charia

VARIABLE	FREQUENCY	PERCENT
AGE		
≥ 74	100	66.7
≤75	50	33.3
SEX		
Male	54	36.0
Female	96	640
MARITAL STATUS		
Single	9	6.0
Married	75	50.0
Widowed	66	44.0
EDUCATIONAL ATTAINMENT		
No formal education/cannot read and write in any language	123	83.1
No formal education but can read and write in at least on language	4	2.7
Primary level	1	0.7
Junior High School level	10	6.8
Senior High School level	2	1.4
Tertiary (vocational, training college, polytechnic and university)	8	5.4
ETHNICITY		
Native	150	100.0
Migrant	0	0.0
RELIGION		
Christian	102	68.0
Islam	28	18.7
African Traditional Religion	18	12.0
None	2	1.3
OCCUPATION		
Agriculture	91	61.9
Business	27	18.4
Service	8	5.4
No work	21	14.3
TOTAL	**150**	**100.0**

Source: Field Survey. (October, 2014)

Sex

Females constituted majority of the respondents. They formed 64% of the sample with the males forming 33%. This is not surprising neither can it be considered as a bias. It is noted in many parts of the world including Ghana that life expectancy of women is higher than that of men. This explains why the widows (65.6%) outnumber the widowers (5.6%) as shown in Table 1. Furthermore, report of the 2010 population and housing census of Ghana revealed that there were more females (51.2%) in Ghana than males (48.8) (GSS, 2013).

Marital Status

From table 1, majority of the aged in the Charia community were either married or widowed. The statistics showed that 50% were married while 44% were found to have lost their spouses. On the other hand, 6% indicated that they were single. It was noticed that most of the females lost their spouses while majority of the males had their spouses whom they were living with.

Education

The educational attainment among the aged in the Charia was found to be very low. In respect to this, 83.1% had no any formal education and thus; cannot read and write in any language. However, there were 5.4% who had attained tertiary level education. Also, those with junior High School level education constituted 6.8%. The lack of education which is a poor social condition can lead to poor health and poor economic conditions. The ultimate effect of these may be lack of participation and insecurity hence a passive live style at old age as indicated in Fig. 1.

Ethnicity

All the respondents confirmed that they were natives of Charia. Though there was no any explanation to this, the

reason could be the fact that people are inclined to go back to their respective homelands at old age.

Religion

In terms of religion, Christianity was the dominant and can be seen from Table 1. It constituted 68% of the sample. The second dominant religion was Islam forming 18.7%, followed by the African Traditional Religion which constituted 12%. Those who did not associate themselves with any religion made up of only 1.3%. Again, the 2010 population and housing census report of Ghana noticed that Christianity was the dominant religion in the country. The domination of Christians in the Charia community is an attestation of the national trend in terms of religious affiliation.

Occupation

The occupational distribution of the aged in Charia indicated that 61.9% were into agricultural activities, 18.4% in business activities while 5.4% were found in the service sector. It is important to indicate however that 14.3% did not have any work to do or cannot even work (see Table 1). Since agriculture in Ghana mostly is labour intensive and requires a lot of energy, the implication is that output levels of the aged would be reduced with majority being found in the agricultural sector.

1.4.2 Health Experiences of the Aged in Charia

The numerous health problems associated with old age as noted by Tawiah (2011) and Ocansey et al., (2013) were unveiled from the analyses of the responses from the aged of Charia. Inferentially, the aged can be said to have frequent ailments. On this note, 93.3% agreed that the frequency at which they experienced physical health challenges had increased tremendously as compared to their youthful ages. Consequently, the number of disabilities also increased, according to them. Attesting to this view 81.9% indicated that they have experienced many kinds of disabilities including poor vision, hearing problems, forgetfulness and lack of emotional control. Those who held contrary views about this assertion made up of only 18.2%.

In order to ascertain the frequency of diseases among the aged, a question was asked requiring the number of times one fell sick within the past one month. It was clear that most of the aged frequently fall sick. The statistics showed that 38.3% had at least experienced some kind of ailments within the last one month. Also, 30.2% confirmed that they have experienced more than one case of physical health problems. On the other hand, 31.5% indicated that they did not experience any kind of health problems for the past one month (see Table 2). The poor economic conditions of the aged in Charia can probably be the cause of their poor health which would signifies an attestation of the framework in Fig. 1.

Table 2. Frequency of sickness during the past one month

		Frequency	Percent
	None	47	31.5
	Once	57	38.3
	More than once	45	30.2
	Total	149	100.0

Source: Field Survey. (October, 2014)

One can see from Table 2 that the frequency of ill health among the aged is high. The finding is an attestation to the United Nations (2004:3-4) assessing that the aged require additional care and treatment. The aged were asked to assess their state of health whether it was very good, good, bad or very bad. Responding to this, 10.7%, 43%, 37.6% and 8.7% described their state of health as very good, good, bad and very bad respectively. An analysis of the statistics shows that 53.7% felt their state of health was either very good or good while another 46.3% felt their state of health was either bad or very bad which is not good for the age group.

An old woman recounted her health experience in a focus group discussion saying that;

> As you can see me I am very old and lost a greater part of my energy. The other problem is that I frequently fall sick. I know that it is all because I am old, because I use not to fall ill regularly when I was young.

In a similar manner, an old man attested to his poor health when he stated that;

> As for me my waste is my problem. It is always paining all the time. I am now fed up with the medication but if I don't take medicine I cannot get up. I cannot also hear well these days. As I am sitting now if I distance myself small from you I am "resting", because if you call me I will not hear.

Table 3. Age and health status cross tabulation

			Age group in years		Total (%)
			60-74	75 and above	
How many times did you fall sick during the past one month?	None	Count	31	16	47
		Expected Count	31.2	15.8	47.0
		% within Age group in years	31.3%	32.0%	31.5%
	Once	Count	41	16	57
		Expected Count	37.9	19.1	57.0
		% within Age group in years	41.4%	32.0%	38.3%
	More than once	Count	27	18	45
		Expected Count	29.9	15.1	45.0
		% within Age group in years	27.3%	36.0%	30.2%
Total		Count	99	50	149
		Expected Count	99.0	50.0	149.0
		% within Age group in years	**100.0%**	**100.0%**	**100.0%**

Source: Field Survey, 2014

Observing from Table 3, there is no remarkable relationship between the age of respondents and their health status. It is shown that 31.3% of the "Young old", thus 60-74 age group indicated that they have not experienced any health problem within the past one month. On the other hand, 32% of the "old old", thus the 75 and above age group confirmed that they have not also experienced any health problem. For those who fell sick once for the past one month, 41.4% belongs to the "young old" while the "old old" formed part of 32%. However, for those who have experienced more than one health problem within the past one month, 27.3% were within the age 60-74 group while 36% fell into the 75 and above age group.

Though greater percentage of the "old old" fell sick more than once in the past one month more than the "young old", this cannot be attributed to age. In order to conclude with validity whether there is a statistically significant relationship between age and health status, there is the need to do the chi-square test of independence.

Table 4. Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.612[a]	2	.447
Likelihood Ratio	1.613	2	.446
Linear-by-Linear Association	.346	1	.557
N of Valid Cases	149		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.10.

Source: Field Survey. [October, 2014]

The chi-square analysis from Table 4 gives a P-value of 0.447 which implies that there is no statistically significant relationship between the variables being tested, with a high level of confidence. With this revelation, there is strong evidence to reject the null hypothesis that health challenges of the aged in Charia are not age related. On the other hand, the alternative hypothesis that health challenges of the aged in Charia are age related is maintained based on the strong evidence obtained from the Pearson chi-square test of independence.

With the frequent and numerous health problems, it was prudent to find out where they seek health care assistance when ill. A larger number forming 95.3% said they seek health care assistance from Medical Doctors, thus orthodox medicine. This is a confirmation of what a senior nurse at the Charia Health Centre said during a face-to-face interview session when she indicated that the aged usually visit the centre for health care assistance. On the other hand, 3.4% maintained that they visit Traditional healers with their health problems while an insignificant proportion held the view that they pray to God and visit Spiritualists. A contradiction that was found out was that though they claim they seek health care assistance from Medical Doctors, majority of them seldom visit the hospital when sick. In relation to this issue, 71.8% confessed that they seldom visit the hospital when sick with only 8.7% indicating that they often visit the hospital when sick. A 70 year old woman in a Focus

Group Discussion emphatically stated that;

> As a matter of fact, if I am sick, inasmuch as I am not unconscious, I will not allow for them to send me to hospital to go and suffer. Because as I am sitting now I have no money and I don't also have children. So I don't want to put anybody into that trouble of sending me to hospital and incurring the cost. I have health insurance but if I cannot walk to the hospital on my own, I will not let anybody send me there.

According to them, several factors work side by side culminating to their inability and unwillingness to visit the hospital, even though they were registered under the National Health Insurance Scheme. They cited factors such as difficulties in waiting at health care centres; difficulties in moving to health care centres and lack of family support as some of the culprits driving them away from attending hospitals. In totality, this is what a senior nurse (the in charge) of the Charia health centre had to say when she was asked whether the aged go to the Charia health centre for health care assistance and her personal observation about the general health conditions of the elderly people of Charia;

> Yes, they do come. My observation however is that most of the aged within the Charia community are not healthy. There seems to be a lack of family care for the aged. Look at the old man who just left, he is visually impaired. Instead of somebody leading him, they left him to come all alone! How can he even go by the prescription that is being given? He might not come next time.

Another revelation was that most of the diseases confronting the aged were chronic which kept on recurring. Responding to this, 96.6% complained about chronic diseases.

1.4.3 Social Experiences of the Aged in Charia

It is increasingly becoming a general consensus worldwide and for that matter Ghana, that the aged are gradually losing their dignity (Cramton, 2009; Tawiah, 2011). The situation has been attributed to the weakening of the extended family system (Kwankye, 2013; Ba-Ama and YaabaAckah, 2014). The development triggered the interest of the researchers to investigate into some social issues of the aged in Charia. In order to find out the criteria of becoming the head of the extended family as well as the household, questions were asked regarding whether one was the oldest in the extended family. The interest in knowing whether one was the head of the house hold was necessitated because it constitutes some form of dignity among the aged. Notably, the Regional Director of Social Welfare of the Upper West Region also acknowledged the importance of being the head of a family. The Director, during a face-to-face interview stated that.

> Those days the head of the extended family use to be a very important and influential figure within that family. All children within the same extended family were given a common family name which was usually the name of the family head. But today, things have changed totally and you can now find two biological brothers fighting over a piece of land. So that big gate that use to be there where everybody in the family passes through is closed and people are now opening their individual gates, naming their children after themselves and does not want them to have anything to do with anybody. This does not auger well for society and for that matter the welfare of the aged. We use to treasure and fear our aged for fear of so many things, today nobody cares.

They were then asked whether they were heads of the extended family. Similar questions were raised in relation to the household. Though 51% attested that they were the oldest in the extended family, only 35.3% were heads of the extended family.

Table 5. Extended Family Headship and Sex Cross tabulation

		Sex		Total
		Male	Female	
Extended family headship	Head	72.2%	14.6%	35.3%
	Not head	27.8%	85.4%	64.7%
Total		**100.0%**	**100.0%**	**100.0%**

Source: Field Survey. [October, 2014]

It can be observed from Table 5 that men were likely to be heads of the extended family than women. Seventy-two (72.2%) of males were heads of the extended family with only 14.6% females being heads of the extended family. Since women naturally have a longer life span than men, most women are likely to be the oldest in the extended family but may not be the family head.

Furthermore, a question was asked regarding who was culturally accepted to become the head of the family. It was agreed by 61.3% that men were culturally accepted to head the family while 37.3% held the view that both men and women were culturally accepted to be the head of the family. Only 1.3% thought women were culturally accepted to head the family. All things being equal, if men are likely to be the head of the family as

shown in this analysis, the implication would be that old women would be more vulnerable to several challenges. Once they are not heads, they have no control over the family property. From the view point of the conceptual framework in Fig.1, women may be most exposed to "passive ageing" since they were more pruned to poor social experiences and may lack participation and security. The Upper West Regional Director of Social Welfare mentioned different sources that confirmed that old women are the people most affected by the difficult life style at old age. To this end he maintained that;

> Nana Apt did a lot of researches and came out with findings that indicated that the women are always the people who feel the pain most because some even have their grandchildren to cater for. Majority of the people from northern Ghana are in Afram plains farming but come home once in a while. Some of them go there and get children, come and dump them with the old ladies meanwhile they come with nothing to support them. They forget that they can be cursed if they continue to do that. You cannot live your mother who took care of you and in the end of the day you reject her, marginalize her and are somewhere doing your own things.

Contrary to the general perception that the aged are humiliated and disrespected, the same thing was not happening in the Charia community. In trying to find out the behaviour of the Charia community members, the youth as well as the family towards the aged, a question was put in that respect. At the family level, 72% rated the respect accorded to the elderly as excellent. Only one person representing 0.7% rated it as bad.

The behaviour of the youth of Charia towards the aged was revealed to be a good one, 44.7% graded it as excellent while 31.3% graded it as very good. Table 6 shows the respect accorded to the aged by the Charia youth.

Table 6. Respect accorded by the youth to the aged

		Frequency	Percent
	Excellent	67	44.7
	Very good	47	31.3
	Good	29	19.3
	Bad	7	4.7
	Total	**150**	**100.0**

Source: Field Survey. [October, 2014]

In a similar revelation, the respective families and the community members in general were helping the aged in one way or the other. They also pay attention to the opinions of the elderly in the Charia community. It is not clear why the aged were given such a respect in the Charia community in an era when respect form the aged was thought to be the thing of the past. It can however be associated with the fact that Charia is still a rural area where the extended families tiers still exist to a greater extend.

It is interesting to note that diverse views were discovered regarding respect for the opinions of the aged. The aged during an FGD indicated that their views were considered outmoded and were not taken seriously by the youth. A 74 year old woman lamented that;

> The attitude of the youth towards the age is not the best. But that is the era in which we are in now, so we see it to be normal. During our youthful ages the way in which we use to fear and respect the age, it does no longer exist]. Currently if an old person wants to advise them they tell you its "colo", meaning we the aged don't know anything so they have forced us to agree that we don't also know anything. So now we have seen ourselves in a different well, and we are watching them to lead us. We are not saying that it is bad because society is constantly changing. We know that the children of today's youth will one day behave differently towards them.

The youth similarly recounted that the aged have and outmoded life style that they find difficult to comply to. This is what a 27 year old woman had to say;

> We do take advice from the aged but most of the times we have to take our own decision because we are in "modern Ghana"; however, the elders are still clinching to an outmoded life style which they expect us to follow. We see some of their advices as intolerable. In the nut shell, I will say that we don't take advice from the aged because for most of the youth, they will not even mine the aged when they speak.

The responses from the FGDs were different from those provided in the questionnaires which were administered to them individually.

Notably, majority of the respondents were found to be living with their children and other family members. To this end, 80% and 19.2% lived with their children and other family members respectively. However, 0.8% did not live with either a child or a family member (see Table 7).

Table 7. Living with children or other family members			
		Frequency	**Percent**
	Children	104	80.0
	Other family members	25	19.2
	None of the above	1	0.8
	Total	**130**	**100.0**

Source: Field Survey. [October, 2014]

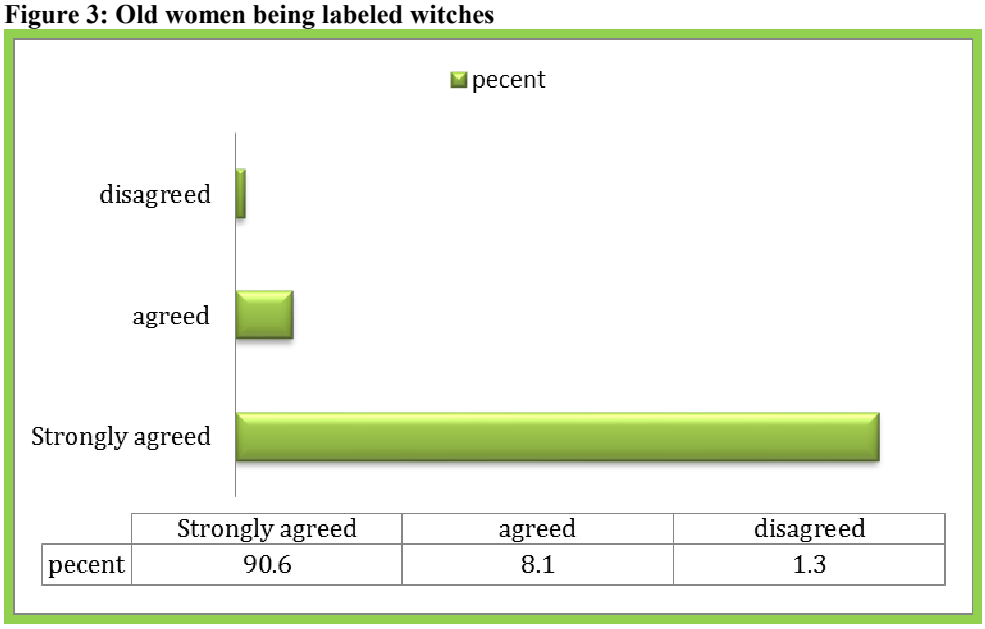
As a matter of fact, one would have expected that the aged within the Charia community would have received a greater support from the family given the fact that they indicated that the aged were respected. However, this was not the case as noted from the respondents' point of view. They claimed that support from the family was limited (see Table 8). it is significant to note that the support being referred to here which they claim was limited had to do with financial support.

Table 8. Limited support from the family to the aged			
		Frequency	Percent
	Strongly agree	46	31.3
	Agree	61	41.5
	Disagree	30	20.4
	Strongly disagree	10	6.8
	Total	147	100.0

Source: Field Survey. [October, 2014]

In terms of respect, it was realized that old men were respected more than old women. The reason for this may be the fact that men assumed leadership positions in most of the families. In fact old women were rather labeled as witches. This act towards the elderly women was found to be unfortunate as it put most of the affected old women in an uncomfortable position within the community. (See fig. 3)

Figure 3: Old women being labeled witches



Source: Field Survey. [October, 2014]

It is obvious form fig. 3 that 90.6% of the respondents believed that old women were labeled as witches. Another 8.1% said they agree while only 1.3% held a contrary view.

It was prudent to find out whether it was the female respondents who said they were labeled as witches. That is to say whether they were bias in their responses.

Table 9. Sex Cross tabulation with whether old women are labeled witches

		Sex		Total
		Male	**Female**	
Old women are labeled as witches	Strongly agree	88.9%	91.6%	90.6%
	Agree	9.3%	7.4%	8.1%
	Disagree	1.9%	1.1%	1.3%
Total		**100.0%**	**100.0%**	**100.0%**

Source: Field Survey. [October, 2014]

The cross tabulation in Table 9 revealed that both the male and female respondents confirmed that the old women were labeled witches. As can be seen from Table 9, 88.9% said they strongly agreed that old women were labeled witches. On their part, 91.1% of the female respondents strongly agreed to the same proposition.

In the mist of the numerous challenges usually confronting the aged, there was no any significant support scheme for the aged of Charia. Lamenting on this challenge, 96% attested to the absence of any support scheme for the aged while only 3.4% held a contrary view claiming there was some kind of support. Those who held the contrary view were however quick to indicate that the support scheme being referred to was the National Health Insurance Scheme which the majority did not recognize as a support scheme.

According to the Upper West Regional Director of Social Welfare, though the Charia community was not covered by their interventions as of the time of this study, they were working hard to reach all communities.

This was how the Director explained the situation;

> By the nature of our department, our mission is to take the lead to promote the welfare of the vulnerable groups, marginalized groups and excluded groups. The aged are included in all these groups and we do this in collaboration with NGOs and other stakeholders. When an aged person in a community is identified to be marginalized, we tackle the family in which that person is coming from first since the family is the basic unit of the society. In effect, we do a lot of awareness creation concerning the needs of the aged. The human life style is such that as one is born, one certainly grows and become old to behave like a child inasmuch as one does not die at youthful ages.
>
> Government has also come out with a support system known as Livelihood Empowerment Against Poverty (LEAP). Here the aged (60 years and above) are given some cash as a form of support. If the person is too old the money is given to a care taker to take care of the aged.
>
> We are already working in most of the villages. In fact Wa Municipal area was the last place of some of these interventions. We are working in all the administrative districts in the region. Indeed, we are working in several rural areas but Charia is not yet covered.
>
> Most of the nearby communities to Wa are not yet covered. That does not mean that we are ignoring them it's just that we cannot cover all the rural communities at the same time. Our main aim is that this LEAP programmes will cover the aged in all communities both rural and urban.

1.4.4 Economic experiences of the aged in Charia

Economic security of the aged is a subject of worry, and it is more so with those in the rural areas. The aged in the rural communities do not usually have any form of savings to safeguard their old age (Kwankye, 20130). The findings of Kwankye (2013) concerning the poor economic conditions of the aged is in consonance with the conceptual framework in Fig. 1 which postulates, that the aged have poor economic experiences leading to poor health, lack of participation and insecurity and consequently resulting into "passive ageing". The aged need economic support so that they would be able to meet some of their basic needs in society. As a matter of fact, questions were raised in the economic dimension of the aged of Charia. Prominent among these questions was a question regarding the monthly income of the aged. The majority (84.4%) indicated that their monthly income was either thirty Ghana cedis (GH₵ 30.0) or less. Only 15.6% maintained that their monthly income was above thirty Ghana cedis (GH₵ 30.0). These figures serve to attest to the fact that the aged are really poor in terms of economic conditions.

Table 10. Monthly income of the aged of Charia

		Frequency	percent
	Gh 30.0 and below	103	84.4
	Gh 31.0 and above	19	15.6
	Total	122	100.0

Source: Field Survey. [October, 2014]

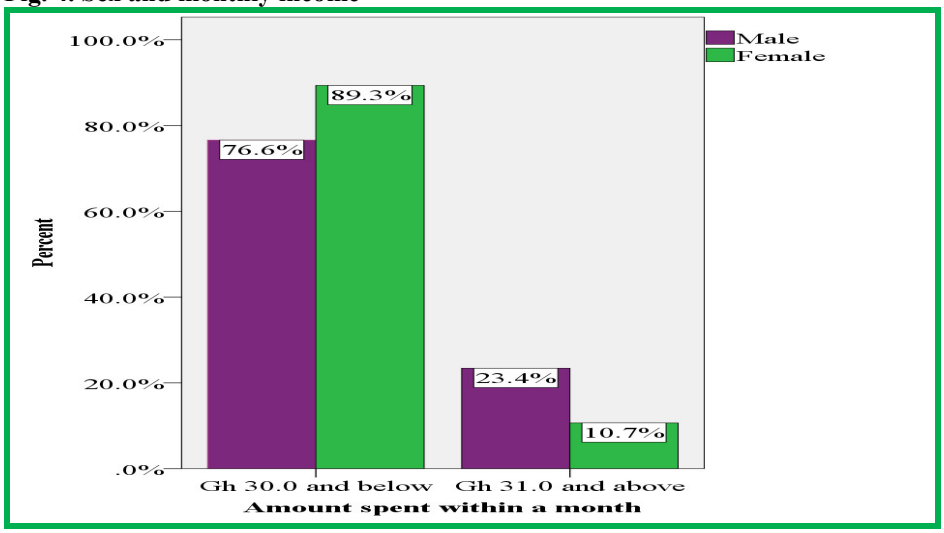
From Table 10, it is conspicuously clear that almost all the aged in the Charia community were caught in the hard core poverty net. It is rather sad that the aged are far below the poverty line. One could conclude with certainty that the aged were in financial crises and needed the support of society.

Table 11. Sex and monthly income

		Sex		Total
		Male	Female	
Amount spent	Gh 30.0 and below	76.6%	89.3%	84.4%
	Gh 31.0 and above	23.4%	10.7%	15.6%
	Total	**100.0%**	**100.0%**	**100.0%**

Source: Field Survey. [October, 2014]

Fig. 4. Sex and monthly income



Source: Field Survey. [October, 2014]

It is critical to note from Table 11 and Figure 4 that the amount of money spent within a month was more or less influenced by the sex of respondents. The indication was that more males than females spent more than GH₵ 30.0 per month. It can be noted that while 76.6% of males within the aged cohort for this study spent less than the said amount, 89.3% of female spent less than the same amount. With those who spent above GH₵ 30.0, 23.4% were males with 10.7 forming the females' proportion. In this regards, female were more likely to be poorer than their male counterparts.

Analyses of the data show that output levels of the aged had reduced drastically. This is in consonance with Kwankye (2013) findings that the aged are incapacitated and are unable to produce fully. Again, the words of an old woman in a focus group discussion served to buttress the same scenario, when she stated that;

> Those days, I did a lot of pito brewing, I did dawadawa business extensively. When it comes to pottery, I did a lot of molding but now, I can no longer do any of these. That time I use to hustle a lot. In fact, I really worked. Sometimes when I flash back the olden days I saw that I did a lot of work.

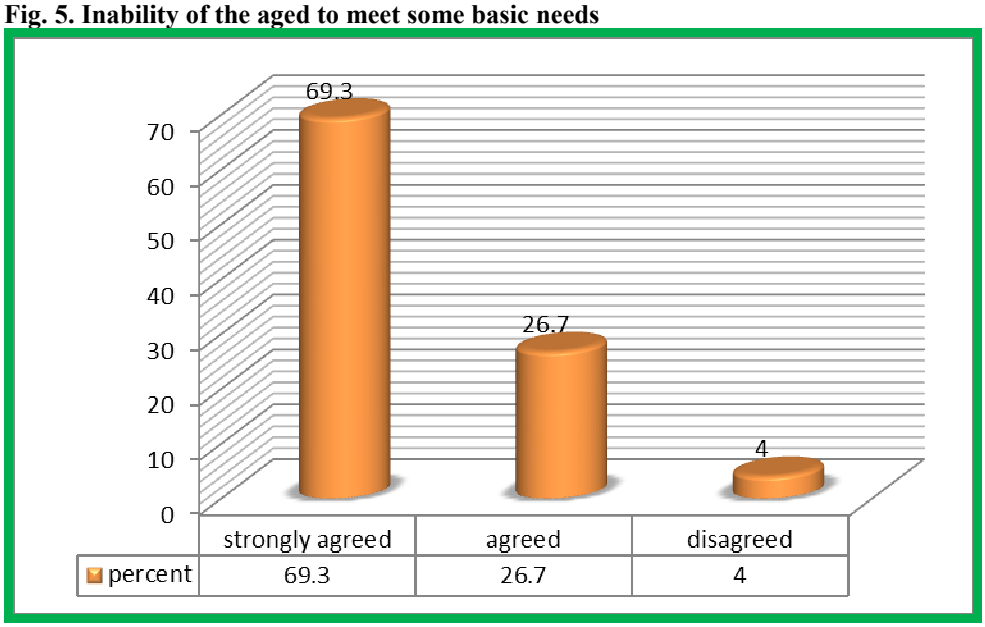
It is not surprising that the output levels of the aged especially those in the Charia community have reduced. The occupational analyses indicated that majority of the respondents were found to be working in the agricultural sector which is usually labour intensive and required a lot of energy. Clearly, the aged, not being energetic are unable to produce much. On the basis of the reduction in output levels, 83.3% strongly agreed that their output levels have reduced with only one person representing 0.7% holding a contrary view.

When asked whether they were content with their current financial state, only 18.9% responded affirmatively with the majority (81.1%) holding a negative perception about their financial state. Furthermore, the poor financial state of majority of the aged was blamed on the fact that they were old and could not work to produce much.

The respondents were asked to rate their returns from the work they do. In doing so, 0.8% and 4.5% rated it as very high and high respectively. On the other hand 59.8% and 34.8% rated it as low and very low respectively. The most significant factor that has been attributed to the reduction in output and low returns was the fact that the number of working hours have reduced.

The ultimate implication of these economic woes of the aged is the inability to meet some of their basic needs necessary for their up keep.

Fig. 5. Inability of the aged to meet some basic needs



Source: Field Survey. [October, 2014]

Drawing from Figure 5, 69.3% strongly agreed that they were unable to meet some basic needs due to economic constrain with another 26.7% who simply agreed to that. However, 4% disagreed with the subject.

It was also revealed that the economic status of the aged was largely dependent on donations from relatives. During an FGD, all the aged declared that their source of income was largely dependent up donations from relatives. This was the reaction of an old woman to the issue.

> If you have somebody who will give you money the person will give you. But where you do not have anybody to give you money where will you get it? Me for instance I don't have any child. I have given birth to many children and all the men passed away living only the women who are also married somewhere. But sometimes, other relatives come and give something small which is usually appreciated.

During another FGD with the Charia youth, they also said the aged can only get money through donations. Commenting on this matter, a 24 year old young man stated that;

> They don't do anything, so unless donations from people they cannot get money from anywhere. It is we the youth that can help them. For example, an elderly person may want you to do something for him/her, doing it for the person may be some kind of help for him/her or if I have something that they need, I can give it to them in order to help them.
>
> The aged are helpful in diverse ways. For example if a youth wants to travel from the family or want to embark on a project and inform the head of the family or an elderly person in the family, though the person does not have anything thing to do, they give motivational speeches that we always remember wherever we find ourselves. So in return, we offer them something small to make them happy.

However, these donations from relatives were said to be limited. Probably, the limited donations from relatives might also be the explanation to the limited monthly expenditure of most of the aged.

It is significant to note that though cash was not always donated to the aged, their feeding was being catered for. In this regards, 89.3% confirmed that they were food secured even though 10.7% thought otherwise. To buttress the fact that they were food secured through relatives, 38.3% explained that they were catered for by their children while 35.9% claimed that they were provided with food by other family members. It must also be mentioned that 25.8% ensured their own food security.

1.5 Conclusion

After critical analyses of the data, several findings came out. Some of these findings seek to reiterate what other researchers have found concerning the aged and the larger society. However, there were some unanticipated findings which need to be echoed so that pro-age policy measures are geared toward the welfare of the aged some vital findings of the study are as follows.

- Old women were found to be the most vulnerable to the difficult life style at old age. Women were found to have a limited space of operation in terms of family headship, due to the cultural setting of

Charia.

- Another point to note is that; though the aged confirmed that they were being respected by the youth for their old age, their opinions and advices were not taken seriously.
- Most of the elderly people were being catered for in terms of feeding. When it comes to finances the aged were found to be at a very disadvantage position.
- Majority also confirmed that the aged seldom visit the hospital/health centre even though they often fall sick.
- Finally, there was no any support scheme for the aged of Charia i.e. No Governmental/ nongovernmental organization exist in Charia support the aged.

1.6 Recommendations

In respect to the findings from this study, it was necessary for certain recommendations to be put forward. The intent of these recommendations is to inform interested parties and allied stakeholders in helping the aged including NGOs, the Department of Social Welfare, all stakeholders and pro age policy formulators about some pressing issues concerning the aged in the study area and Ghana as a whole.

- First and foremost, the youth of Charia should be educated to see the aged especially old women as the youth women of yesterday. Proper care for the aged should be a culture among the youth so that when they also grow old, they would not suffer similar consequences
- It is also recommended that the Livelihood Empowerment Against Poverty (LEAP) programme; a government of Ghana's initiative at helping the aged with some cash should be executed with all seriousness in order to robe in more beneficiaries. This will serve to address some of the financial challenges of the aged especially those without any support scheme as revealed in the case of Charia. Indeed, if the LEAP programme is well managed it can be of great help to the aged.
- Finally, it is advisable that the aged seek for health care assistance whenever they are sick. Family members and other relatives are therefore encouraged to give them the necessary support to visit health care centres in the event of any diseases.

References

Aboderin, I. (2010). Understanding and Advancing the Health of Older Population in sub-Saharan Africa: Policy Perspectives and Evidence Needs. *Public Health Review, Vol. 32, No. 2, 357-376.*

Apt, N. (n.d.). Rapid Urbanization and Living arrangements of Elder Persons in Africa. Centre for Social Policy Studies, University of Ghana, Legon, Ghana.

Ba-Ama, E. and YaabaAckah, P. (2014). Causes of Neglect of the Aged in Secondi-Takoradi Metropolis, Ghana. *International Research Journal of Arts and Social Science Vol. 3(1) pp. 8-16.*

Beard, J. R. and Petitot, C. (2010). Ageing and Urbanization: Can Cities be Designed to Foster Active Ageing? *Public Health Review, Vol. 32, No 2. 427-450.*

Crampton, A. (2009). Global Aging: Emerging Challenges. Boston University, the Fredrick S. Pardee Centre for the Study of the Future. No. 6.

Creswell, J.W. (2009). Research Design: Qualitative, Quantitative and Mixed Methods Approaches, (third edition). Sage Publications, Inc., Thousand Oaks,

Dziechciaz, M., Guty, E., Wojtowicz, A., Filip, R. (2012). Social and Health Care Needs of Elderly People Living in the Countryside in Poland. *Annals of Agricultural and Environmental Medicine Vol. 19, No 4, 746-750.*

Ghana Country Report on the Implementation of the Madrid International Plan of Action on Ageing (MIPAA) (2007)

Ghana Statistical Service (2005). Population Data Analysis Report. Volume 1, Socio-economic and Demographic Trends. Accra, Ghana.

Ghana Statistical Service (2013a). The Elderly in Ghana: 2010 Population and Housing Census Report. Accra, Ghana.

Ghana Statistical Service (2013b). Demographic, Social, Economic and Housing Characteristics: 2010 Population and Housing Census Report. Accra, Ghana.

Karlberg, T. (2003). Elderly Population in Ghana: About Roles and Life Situation from their own Perspective. www.onebromissionsskola.se/.../FSP%200708%Therese%20karlberg%...

Kwankye, S. O. (2013). Growing Old in Ghana: Health and Economic Implications (Executive Director, National Population Council, Accra, Ghana). *Postgraduate Medical Journal of Ghana Vol. 2, No. 2.*

Mba, C. J. (n.d.). Population Aging and Poverty in Rural Ghana. Regional Institute of Population Studies, University of Ghana, P.O. Box 96, Legon, Ghana. wikieducator.org/images/2/26/AGRIC_chuksmba.pdf

National council on Aging and Older People (2005). An age Friendly Society: A Position Statement. 22 Clawilliam Square Grand Canal Quay. Dubblin 2. Report No. 88

Niles, K. A. (2010). The Aged, a New Power for Development: Implying the Importance of an International Framework Addressing their Needs in the Caribbeans.

Ocansey, S., Awusabo-Asare, K., Kumi-Kyereme, A. and Boadi-Kusi, S. B. (2013). Ocular Health of the Emerging Elderly Population in Ghana: Evidence from a Peri-Urban Community. *Health Aging and Clinical Care in the Elderly 5, 21-31*

Ozsen, T. and Tokuno, S. (2008). The Social Role and Position of Elderly in Order to Sustain Rural Life in Japan. Kumamoto University, Graduate School of Social Science and Cultural Science; Kumamoto, Japan, 860-8555

Schroder-Butterfill, E. (2003). 'Pillars of the Family'- Support Provided By the Elderly in Indonesia. Working Paper Number WP303, Oxford Institute of Aging. www.ageing.ox.ac.uk/workingpaper_300.fdf

Tawiah, E. O. (2011). Population and Ageing: A Profile and Emerging Issues. *African Population Studies Vol. 25, 2*. Regional Institute for Population Studies, University of Ghana. Legon, Ghana. United Nations (2002). Report of the Second World Assembly on Ageing. A/CONF.197/9/ New York.

Wa Municipal Assembly (2010). Human Development Report 2010: Resource Endowment, Investment Opportunities and the Attainment of MDGs. United Nations Development Programme, Ghana Office, Accra. www.undpgha.org/docs/wa%20ACOMPLISHED%20R3.pdf

WHO (2002). Active Ageing: A Policy Framework. Noncommunicable Disease Prevention and Health Promotion. Ageing and Life Course, 20 Avenue Appia. CH1211 Geneva 27, Switzerland