Research on Humanities and Social Sciences
ISSN (Paper)2224-5766 ISSN (Online)2225-0484 (Online)
Vol.5, No.2, 2015

Basic Needs for the Aged in Selected Districts in Ashanti Region of Ghana.

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Abstract
The issue of the aged is a major concern to the society and has hence influenced a number of policies in their interest; yet, the conditions of the aged have not changed much. This study therefore sought to investigate the healthcare, housing, social and financial support given to the aged in the Kumasi Metropolis and Bosomtwi District within the Ashanti Region of Ghana. Purposive sampling technique was adopted for the selection of the study area while random sampling was used in selecting 264 aged respondents. Their care givers were also interviewed; where the aged gave permission to. The religious institutions they attend and other philanthropic institutions that support them were also purposively sampled. Interview guide and questionnaire were used for the collection of data. The survey revealed that 48.9% of the aged respondents lived in their family houses and has some form of social interaction. About 64% however lived without their spouses and visited friends to break boredom. About 58% of the aged respondents suffer from multiple illnesses which are usual of the aged and most of them (63.3%) went for regular medical check-ups to sustain themselves. The study also revealed that, 91.3% of the aged respondents depended on remittances from their children for financial sustenance, which was not reliable as any hiccup in the finances of their children would affect their wellbeing. The implementation of the "Aged Fund" would oversee the wellbeing of the aged; and the establishment of Community Social Centres for social interactions has been recommended. Again, the age limit for the subsidized premium payment of the National Health Insurance Scheme should be reduced from 70 years to 65 years as 28.4% of the aged respondents fell within the 65-69 year age cohort.
Keywords: Aged**,** Wellbeing, Housing, Health care, Social support, financial support.

1 Introduction

As people grow old, they encounter peculiar health problems and thus require special attention in relation to basic care; however they do not receive such attention (Robinson, 2006). In Ghana, the aged population has increased from 4% in 1984 to 5.3% in 2000 (GSS, 2005) and is expected to increase further. Many countries in Sub-Saharan Africa like Ghana have a young population,, these countries are in recent times growing steadily with an increasing elderly (65 years and above) and decreasing younger population (Lagergren, 2002).

Bowen and Atwood (2004) have defined ageing in humans as multi-dimensional which includes physical, psychological and social change. Different institutions and countries have different ways of classifying the age limit for the aged. For example, the 1992 Constitution of Ghana classifies 60 years and above as the age a person must retire from active work. However, the retirement ages for political office holders and the informal sector are undefined; it rather depends on the appointing authority and or how one's health could lead him/her respectively. The National Health Insurance Scheme, considers a 70 year old as aged. For the purpose of this study the Aged are defined as persons 65 years and above in accordance with the Government of Ghana, 2007.

The process of ageing, according to Eliopoulos (2001), is complex; the principles of gerontological nursing practice, look at ageing as a natural process common to all living organisms. The uniqueness of the ageing process is influenced by both exogenous and endogenous factors such as heredity, nutrition, health status, life experience, environment and stress. A lot of issues affect the aged in Ghana; as one increase in age, the level of loneliness increases due to the gradual breakdown of the extended family and the compound housing system (Andersson, 2002); limited social network; loss/ death of friends and spouse, and rejection from relatives. The aged normally have non-communicable and degenerative diseases such as diabetics, hypertension and cancers (Kwankye, 2013). Ageing is highly correlated with long-term physical and mental disability and a number of long-term chronic conditions and this is likely to increase the need for personal care (Nabalamba and Mulle, 2011 cited in Kwankye 2013).

As a result of many problems - financial, social as well as health challenges confronting the ageing population in Ghana, the government has participated in several international conventions, and formulated social intervention policies to help reduce their burden in terms of their health care and other basic needs.

Ghana has participated and adopted the various UN conventions and initiatives on the Aged. These include the First World Assembly on Ageing in 1982, International Year of Older People in 1999, and African Union Labour and Social Affairs Commission meeting in 2002. The recommendations made included the formulation of economic and social policies meant to ensure employment and income security, health, housing, education and social welfare among vulnerable groups such as persons with disabilities and the aged. Ghana also participated in the second World Assembly on Ageing in 2002 and adopted the Madrid International Plan of Action on Ageing (MIPAA). The MIPAA addressed three main areas of concern which are older persons and development; health and well-being into old age and enabling and supportive environment for Ageing (GOG, 2007).

Article 37 (2) (b) of the 1992 Fourth Republican Constitution of Ghana states that the State shall enact appropriate laws to ensure the protection and promotion of all basic human rights and freedom, including the right of the Aged in the development process. The National Development Planning Commission (NDPC) incorporates issues of the aged into the national development frameworks. Other policies formulated by the government to take care of the issue of the aged include the Pension Schemes, National Health Insurance Scheme (NHIS) in 2005, National Social Protection Strategy in 2006 and Ghana National Disability Policy in 2000. The Ministry for Gender, Children and Social Protection, is the institution which has been mandated to safeguard the rights, freedom and welfare of the elderly as provided for in the Constitution of Ghana. It is also responsible to ensure the effective implementation of the National Ageing Policy.

The pension scheme provides financial security (retirement income) to the aged (60 years and above) who have worked in the formal sector and contributed to the pension fund. In Ghana, the 1992 Constitution (Article 37/6) explicitly directs the Government to ensure that contributory schemes are instituted and maintained to guarantee economic security for self-employed. Since majority of the labour force in Ghana work in the informal sector, pension schemes for informal sector workers was introduced in 2005. According to Mr. Joseph Boadi, Ashanti and Brong Ahafo Area Manager of the Informal Sector Fund (SISF) of the Social Security and National Insurance Trust (SSNIT), membership of the fund had risen from 6,577 in 2005, when it became operational, to 90,913 as at October 2011. The fund had grown over the years to a total of GH ¢21,495,358.89 in 2011 (Freiku, 2011).

The Livelihood Empowerment Against Poverty (LEAP) programme is Ghana's National Social Protection Strategy, launched in March 2008 to provide a safety net for the poorest and most marginalized groups in society. It seeks to protect and empower the extreme poor families which include the elderly (aged 65 and above) with cash transfer as well as access to complementary services such as the National Health Insurance Scheme. The programme is been managed by the Department of Social Welfare under the Ministry of Gender, Children and Social Protection. The programme since its inception has expanded each year and has reached over 71,000 households in all 10 regions of the country as of June 2013. The transfer value has tripled in the second half of 2012 and now ranges from a minimum of 24 GH¢ (US$ 12.5) per beneficiary per month to a maximum of 45 GH¢ (US$24.6) for four or more dependents per month. Beneficiaries are paid bi-monthly through the national postal service agency (GOG, 2013).

The Ghana National Disability Policy caters for the welfare of the disabled and the aged. The policy addresses issues such as the Rights, Employment, Education, transportation and the Health care system of persons with disability to eliminate all impediments in the way of disabled and older persons in the performance of their duties as citizens of Ghana. Under the policy, the Ministry of Health is mandated to formulate health policies with the interest of the disabled and the aged in mind and to provide them with free general and specialist medical care, rehabilitative operation treatment and appropriate assistance for persons with total disability (Republic of Ghana, 2006 cited in GOG, 2007). The National Health Insurance Scheme under the Ministry of health seeks the welfare of the general public with much benefits to the aged (70 years and above) such as free registration into the scheme which ensures that the aged have access to free quality health care and also reduce the medical cost of the aged. The National Health Insurance Authority has subsequently registered over one million Ghanaians as elderly and vulnerable persons since the introduction of the scheme in 2005 (Tandoh and Bio, 2014).
Notwithstanding the implementation of the numerous/ various policies and programmes that target the aged, their vulnerability and poverty still persist (NDPC, 2010) and the aged population has declined from 5.3% in

2000 to 4.7 in 2010 (GSS, 2012). In view of this, the study is being conducted to: assess the wellbeing of the aged and make recommendations to inform policy..

2 Research Methodology

The case study approach was used for the study. This was because case study permits in-depth investigation of a phenomenon and uses a variety of data gathering techniques to produce evidence that leads to understanding of the "case" (Yin, 1984). Case study is used to investigate contemporary issue in its real life situation when observing a single group at a single point in time, usually subsequent to some phenomenon that allegedly produced change (Nachmias et al, 1992), and hence was appropriate for the study. Both primary and secondary data were assembled for the research. The secondary data were gathered from related reports, newspapers, journals, articles and World Wide Web (Internet) while the primary data was obtained through direct observation, questionnaire administration and interview guides. Purposive sampling technique was adopted for the selection of the study areas which were Bomso, Oforikrom and Anloga in Kumasi Metropolis (representing urban setting); and Apenkra, Kuntenase and Jachie in Bosomtwi District (representing rural setting) (see Table 1); all in Ashanti Region of Ghana (Plate 1). The selection of these towns were due to the strong organized aged group in the communities. Again, the proximity to and cost effectiveness of going there by the researchers informed their selection. The sample frame of the aged from the six communities was 775 (Compassionate African Aged Foundation) (see Table 1).

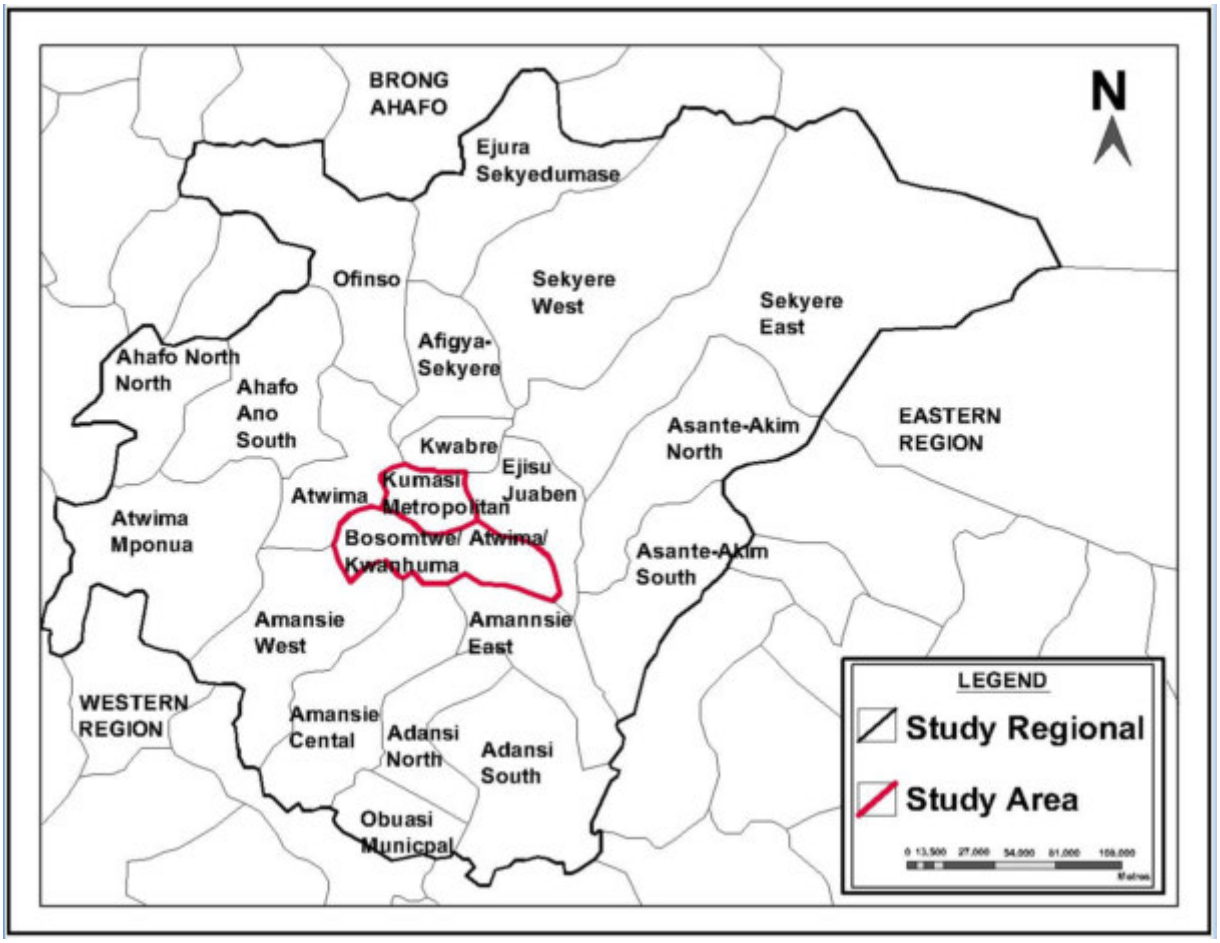

Plate 1: Study Districts in Regional Context

The sample size was determined by a mathematical formula given by Miller and Brewer (2003) as; $n = \frac{N}{1 + N(\alpha)^2}$ where **N** is the sample frame, **n** is the sample size and α is the margin of error (fixed at 5%). The sample size, **n** becomes; n= {775/ [1+ 775(0.05) ^{2}]} = 775/2.937 = 263.87 = 264**.**

A simple proportional formula (P x n/N); where P is the population, was used to select the aged respondents from the communities for the interview, as shown in Table 1.

Table 1: Number of Respondents interviewed in the Study Areas

District	Selected Community	Aged Population			Sample Size		
		Male	Female	Total	Male	Female	Total
Kumasi Metropolis	Bomso	48	53	101	16	18	34
	Oforikrom	64	96	160	22	33	55
	Anloga	54	70	124	18	24	42
Bosomtwi District	Jachie	61	89	150	21	30	51
	Kuntenase	52	73	125	18	25	43
	Apenkra	40	75	115	14	25	39
Total		319	456	775	108	156	264

Source: Compassionate African Aged Foundation/Field Survey, June 2011

Stratified sampling was used to group the males and females into different strata and random sampling was used in selecting from each of the stratum to arrive at the 264 aged respondents. The aged who gave their consent for their caregivers to be interviewed were 52 and 10 religious affiliations which the aged attended were interviewed (see Table 2). The study was carried out from January 2011 to June 2011.

Table 2: Groups Interviewed in the Study Areas

Groups Interviewed	Sample Size
Aged	264
Caregivers	52
District Assembly (DA)	2
Department Of Social Welfare (DSW)	2
Compassionate African Aged Foundation (CAAF)	1
Religious Groups	10
Total	331

Source: Field Survey, June, 2011

The questionnaires were pretested to eliminate ambiguities before the final questionnaire was administered. Both quantitative and qualitative analytical techniques were adopted for the data analysis. The Statistical Package for the Social Sciences (SPSS) 16.0 version was used to facilitate the analysis of the quantitative data and descriptions were used to analyse the qualitative data. The results were presented as write-up for the qualitative data and in tables and charts for the quantitative data. Finally, conclusions in relation to the findings and policy recommendations were made.

3 Results and Discussions

3.1 Socio-Economic Characteristics of the Aged Respondents

The characteristics of the aged respondents, in terms of their age, gender, educational and marital statuses have been discussed in this section.

3.1.1 Age and Gender

The study revealed that females dominated (both in the urban and rural areas) the aged respondents, representing 60.6% (see Table 3) following the. national trend where female aged dominates the males by 2.4% (GSS, 2012)). The results showed that 28.4% of the aged respondents fell within the 65-69 age cohorts whom the NHIS do not include for the free premium to register into the scheme.(see Table 3)..

Table 3: Response by Gender and Age

Community	KMA		BDA		Overall	
	Frequency (F)	(%)	F	%	F	%
Gender						
Male	54	41.2	50	37.6	104	39.4
Female	77	58.8	83	62.4	160	60.6
Total	131	100.0	133	100.0	264	100.0
Age Cohort						
65-69	37	28.2	38	28.6	75	28.4
70-74	38	29.0	37	27.8	75	28.4
75-79	22	16.8	26	19.5	48	18.2
80-84	15	11.5	24	18.0	39	14.8
85-89	18	13.7	3	2.3	21	8.0
90-94	1	0.8	2	1.5	3	1.1
95+	0	0.0	3	2.3	3	1.1
Total	131	100.0	133	100.0	264	100.0

Source: Field Survey, June, 2011

3.1.2 Educational Level

Education allows an individual to gain access to better economic opportunities, earn a good salary and enhance his/her socio-economic conditions even after retirement. As one's income increases, his/her standard of living relatively improves and is likely to be able to save to meet their future needs better than those whose incomes are low (NDPC, 2010).

Empirical evidence has revealed that majority of older persons have no formal education in Ghana (GOG, 2007). The study revealed that 51.9% of the aged in the rural communities as against 45.8% in the urban communities have not had formal education. This finding is better than GSS ' findings,(2000), which indicated that 80% of older persons in rural Ghana have not had any formal education. On tertiary education however, the study revealed 7.5% of rural as against 6.9% urban educated people.This has been attributed to those who have returned to live in the rural area after formally retiring from active employment in the urban areas.. More aged in the urban communities had formal education at the basic and secondary school levels than those in the rural communities (i.e. 25.2% and 12.2% as against 20.3% and 9.0%) respectively. This implies that relatively, more aged people in the urban communities have better standard of living than those in the rural communities.

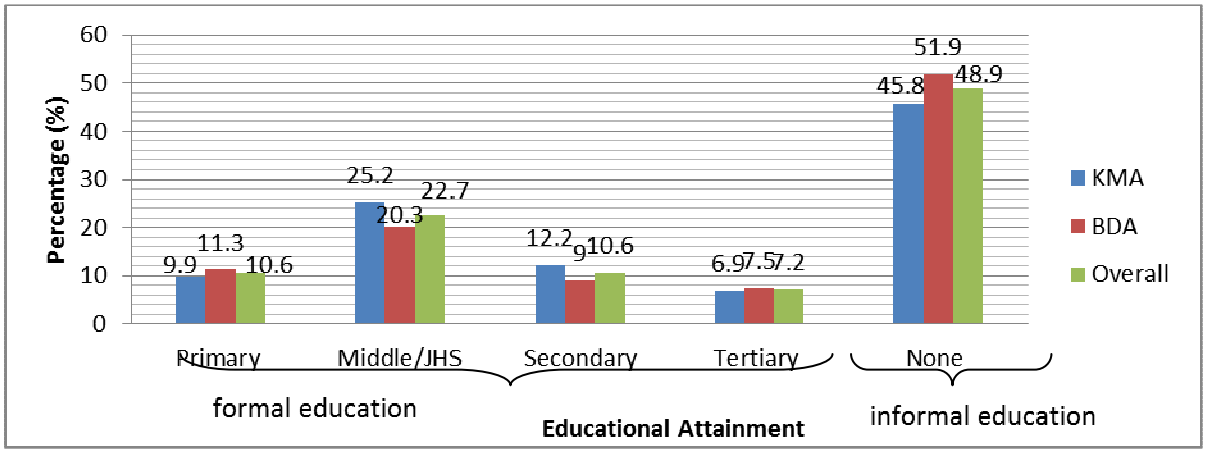

Figure 1: Educational Status of Aged Respondents

Source: Field Survey, June, 2011

3.1.3 Marital Status

The common source of emotional support (such as empathy, concern, caring, love and trust) is normally that which comes from family and close friends (House, 1981). Marriage as a union between two people, help create some form of social interaction which improve the social life of each individual. People who are not married and live alone are therefore less likely to enjoy their social life. Poor social life is associated with mental health problems, such as depression (Dalgar, 1995).

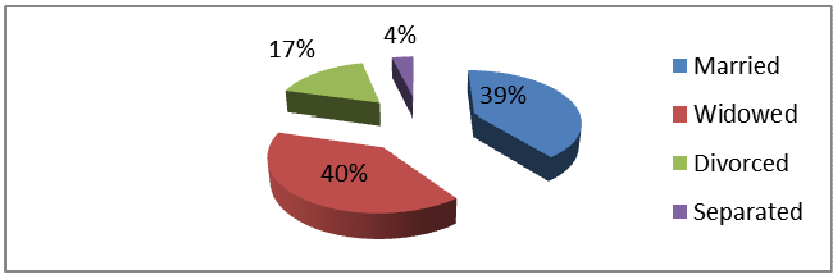

Figure 2: Marital Status of the Aged Respondents

Source: Field Survey, June, 2011

From Figure 2, 61% of the aged are not currently married (comprising widowed-40%, divorced-17% and separated-4%). Only 39% were married and were living with their spouse at old age. The implication is that, majority of the aged may lack emotional and social support which is received from spouses and this could affect their health (Dalgard, 1995). Again, males dominated the married respondents by 26.9% as against 15.9% for females. This finding is not consistent with GSS (2012), where females are more likely to be married (43.9%) than males (41.7%) in Ghana. But confirms Tawiah (2011) findings among the aged population where males are 2.6 times more likely to be married as compared to their female counterparts. This denotes that, majority of the females may suffer emotionally as compared to their male counterparts because, the males relatively stay in marriage longer. This finding is not surprising since traditional beliefs and practices supports males to re-marry after divorce and death of their spouses. Traditionally, males are the bread winners of the family. The greater proportion of females (44.3%) who are widowed or Divorced are likely to face financial difficulties since they would have to cater for themselves if they do not earn a pension or receive financial support from their children or relatives. It is well known that women tend to outlive men; therefore the need to educate females on financial planning becomes very crucial to help them become financially independent long before retirement, divorce or widowhood. According to figure 3, more aged (46.6%) in the rural areas were married than in the urban areas (39%). The unmarried however were 61.1% in the urban areas.

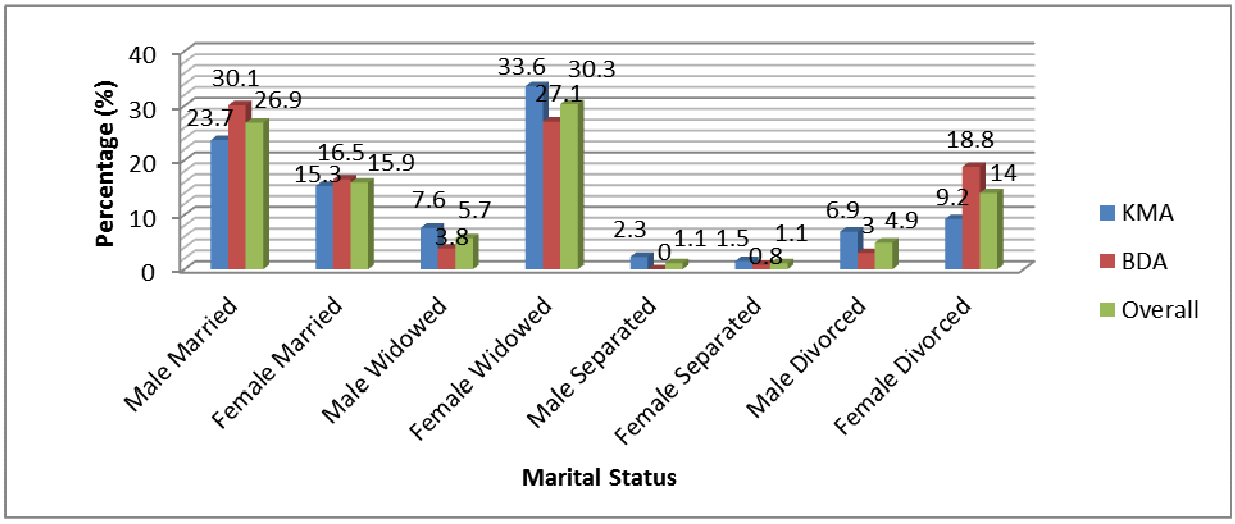

Figure 3: Marital Status by Gender
Source: Field Survey, June, 2011

3.2 Financial Situation of the Aged

This section assesses the employment status of the aged respondents; their sources of income and their expenditure pattern.

Occupation of the Aged Respondents

The study assessed two categories of occupation, the previous and current occupation (i.e. before and after retirement jobs respectively). The majority of the aged were previously employed in the service/commerce sector in both the urban (54.2%) and rural communities (48.9%). For the urban areas, agriculture was the least engaged employment (2.3%). Agriculture employed the highest (84.2%) in the rural areas but the least (21.1%) in the urban areas. This finding is consistent with GOG (2007), which said that a large number (80%) of the Aged are employed in the agricultural sector because the youth who have the physical strength to go into agriculture mostly migrate to the urban areas in search of white colour jobs. In the urban areas however, service/commerce sector employed 45% of the aged (Figure 4).

The average sectoral employment for the previous occupation was dominated by service/commerce (51.5%) followed by industry (32.2 %) and the least was agriculture at 16.3 %. Currently, agriculture employed 42.4% in the study area which is higher than the active labour force employed in the agricultural sector in Ghana (GSS, 2012). This finding is however worrisome as the aged respondents do not have enough strength to undertake farming activities and this may affect food security in the study areas. The non-economic active aged respondents constituted 28%, they depended on their pension, children, relatives and or their savings or investment; and any hiccup in their families' finances would cause 'disaster' for them.

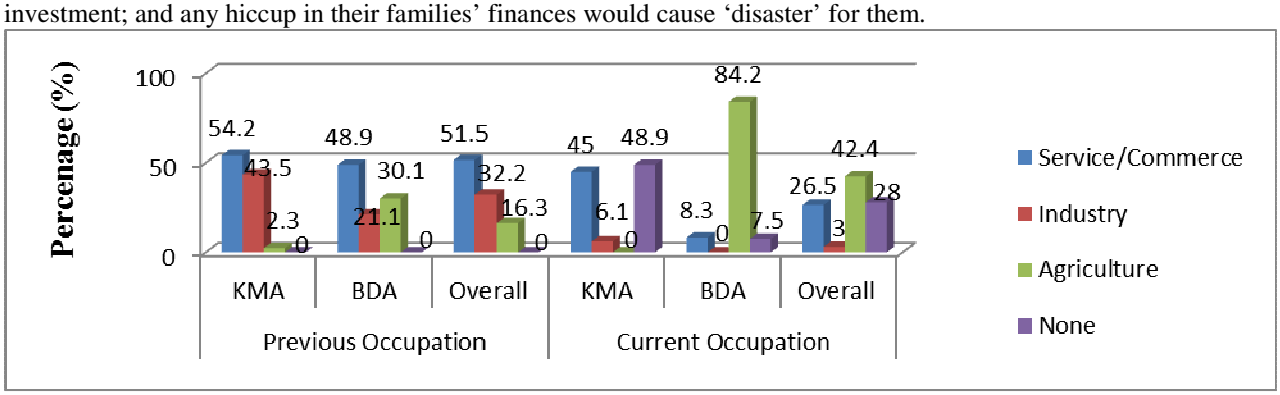

Figure 4: Occupation of the Aged Respondents
Source: Field Survey, June. 2011

3.2.1 Sources of Income of the Aged

The study revealed two main sources of income for the aged; the sustained and unsustained incomes. However, you could find an aged receiving income from both sources at the same time. The sustained incomes are the ones the aged has power over its source and this include amount from present occupation, rent on property, pension and other investments. The unsustained on the other hand, are the ones the aged has no power over its source and it includes remittances from children and other relatives, Livelihood Empowerment Against Poverty (LEAP), Church and other philanthropic institutional support.

The study as depicted in Table 4 revealed that, the aged with the highest incomes were those receiving pension representing 22.3% with a mean income of GH₵ 139.42. The LEAP fund was the source which few of the aged (1.1%) benefited from and also had the least average income of GH₵ 26.00. By observation, this group had a low standard of living. About 91.3% of the aged depended on remittances from their children, at a mean income of GH₵ 75.16; this is the source majority of the aged respondents depended on. It can be deduced that, majority of the respondents depend on the unsustained income sources. This implies that, at any point in time if 'something' happens to the source, the aged will not have the needed financial support. Only 36.7% depended on sustained income sources. In times of emergencies (such as sickness, etc) majority of the aged would be at risk as they may not be able to react immediately in financial terms.

Table 4: Sources of Monthly Household Income

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

Source: Field Survey, June, 2011

3.2.3 Expenditure of the Aged

Rationally, every person would spend in relation to his/her income, though; economic principle has it that, wants are insatiable which makes scale of preference an important issue in this case.Table 5 illustrates the monthly expenses incurred by the aged.

Table 5: Monthly Household Expenditure

Expenditure	Percentage (%)	Minimum (Ghȼ)	Maximum (Ghȼ)	Mean (Ghȼ)
Food	100.0	30.00	300.00	137.84
Clothing	14.0	2.00	12.00	5.40
Housing/Rent	32.2	2.00	20.00	8.55
Water	78.0	2.00	50.00	3.97
Electricity	98.8	2.00	70.00	5.85
Transport	81.4	1.00	20.00	4.21
Church/Funeral	90.9	2.00	30.00	6.81
Healthcare	100.0	2.00	45.00	6.02

Source: Field Survey, June, 2011

Some of life's basic requirements are food, shelter, clothing, good health, among others. It is therefore not surprising that all the Aged spent mainly on these items; with mean monthly expenditure of GH₵ 137.84 and GH₵6.02 respectively on food and healthcare. Food and healthcare were the two most basic necessities for the respondents because all of them spent on those items. About 71.6% of the aged respondents access healthcare for free with their NHIS card however, some of them had to spend GH₵ 45 for the treatment of diseases that were not catered for by the NHIS and those who could not afford resorted to self-medication.

3.2.4 Income and Expenditure Analysis of the Aged

Income and expenditure analysis helps to measure the welfare of a person. It shows at a glance how much one is earning at a point in time and how much that individual is spending at that same period. The difference shows either a surplus or deficit and that measure the welfare of that individual or group. Table 6 shows the welfare of the aged respondents using their monthly income-expenditure analysis.

Table 6: Average monthly income and expenditure analysis of the aged respondents

Aged respondents (%)	Monthly average	Household income (Ghȼ)	Household expenditure (Ghȼ)	Difference (Ghȼ)
18.3	Minimum	17.40	5.40	12.0
75.6	Maximum	63.10	68.40	-5.30

Source: Field Survey, June, 2011

From table 6, averagely 18.3% of the Aged earn an average minimum income of about GH₵17.00 and average maximum income of about GH₵63.00. Thus, the aged respondents' average minimum incomes were far below the World Bank's/Millennium Development Goal's recommended minimum income of about one (1) dollar per head per day representing a monthly income of about 30 dollars per head, equivalent to GH₵60.00 per head per month. It was also revealed that, an average of 18.3% of the Aged received an average income of GH₵ 17.40

and spent an average minimum of GH₵5.40.with a surplus of GH₵12.00. But the 75.6% of the aged who earned a maximum of GH₵ 63.10 ended up spending more than they earned (68.40). Thus, the aged will be generally financially sustainable if they live a 'moderate' life. It is when they spend more than their minimum/ average income that they may have to borrow to survive.

3.3 Basic Needs on Food and Nutrition

Food has been described as a necessary component of human survival without which the body system would not function properly (Dalgard, 2009). Averagely, 61% of the aged respondents ate thrice a day and only 0.4% ate once a day (see Table 7). This finding confirms that of Deen (2008) who says one should eat 'three square meals' per day (where 'three square meal' is used as a jargon). This implies, majority of the aged respondents met the "three-square meals a day" requirement slogan, but the quality and quantity of the food in terms of its nutritional value and satisfaction needs much to be desired. Thus, even though their incomes are low, because they know the correlation of eating and body system functioning, they still strive to meet the three square meals a day requirement slogan. About 96.2% of the aged had no diet restrictions while 3.8% of the aged had. This means that, the greater percentage of the aged may not be suffering from chronic diseases such as hypertension or diabetes which demand diet restriction.

Table 7: Number of Times the Aged Respondent Eats Daily

Number of Times	KMA		BDA		Overall	
	F	%	F	%	F	%
Once	0	0	1	0.8	1	0.4
Twice	59	45.0	43	32.3	102	38.6
Thrice	72	55.0	89	66.9	161	61.0
Total	131	100.0	133	100.0	264	100.0

Source: Field Survey, June, 2011

3.4 The Housing Situation of the Aged

According to WHO (2011), housing conditions are likely to affect people's health situation. Inadequate housing contributes to other preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. This section therefore discusses the housing situation (in terms of both facilities and services) for the Aged.

Type of House

The study revealed that, the aged respondents rented, perched, or lived in their family/ own house (see Figure 5). About 45.8% of the aged respondents lived in their family house.

About 61.1% (majority) of the people in the urban area rented houses while 66.9% (majority) in the rural areas lived in their family houses. This kind of family housing system is also good for the wellbeing of the aged as social interaction is enhanced. Comparatively, this figure is higher than the whole of KMA figure where 42% rented (KMA, 2010) and also higher than the 2005 national average of 11.2%.

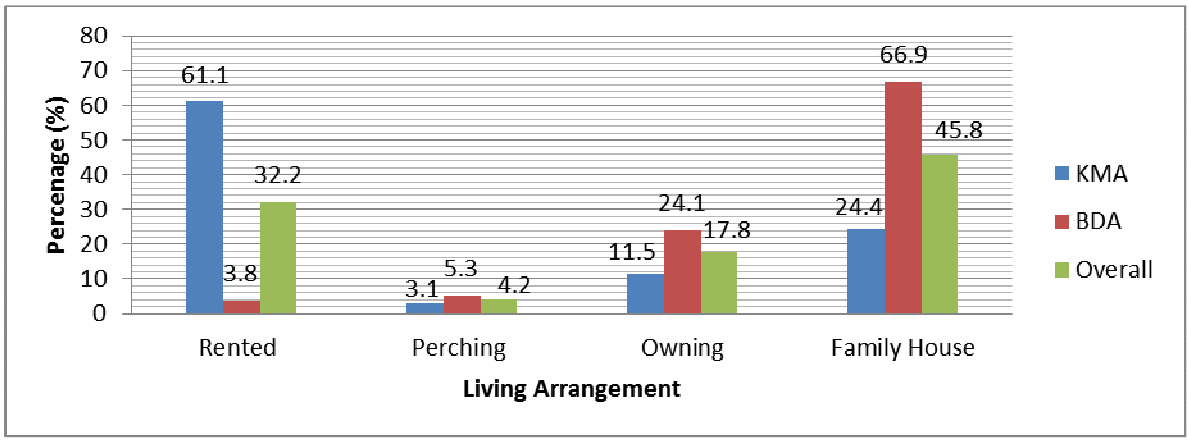

Figure 5: Type of House the Aged Live
Source: Field Survey, June, 2011

3.4.1 Type of Toilet Facility and Place Accessed

Adequate shelter according to this study will mean a good building with appropriate facilities and services. The research identified that all the respondents had access to toilet facility and hence there should be no or less open defecation unless for special reasons. The study revealed that, 83.2% of the aged from the urban communities used Kumasi Ventilated Improved Pit (KVIP), 6.9% used Pit Latrine and only 9.9% used Water Closet (WC). In the rural communities on the other hand, 63.2% used KVIP, 33.1% used Pit latrine and only 3.8% used WC. About 73.1% of the aged respondents used KVIP, 20.1% used Pit latrine and only 6.8% used WC toilet facility. The 6.8% using WC is lower than the national average of 10%. Again, the study revealed that, 80.7% of the Aged accessed toilet facilities from outside their homes. This implies that in terms of access to toilet facility, majority of the aged have to walk outside of their homes to access the facility.

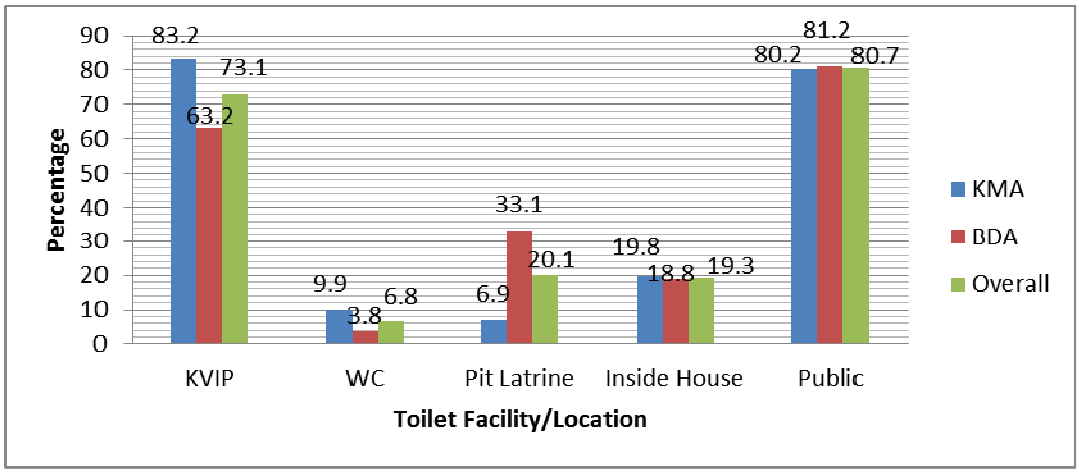

Figure 6: Type of Toilet Facility Used and Where to Access the Facility
Source: Field Survey, June, 2011

3.4.2 Source of Water

Quality water is a necessity for human health. For this reason, the study sought to find out the sources of water the aged respondents depended on for living.

Table 8: Source of Water for Consumption

Community	**KMA**		**BDA**		**Overall**	
Source of water	F	%	F	%	F	%
Pipe-borne	125	95.4	24	18.0	149	56.4
Borehole	2	1.5	87	65.4	89	33.7
Well	4	3.1	22	16.5	26	9.8
Total	131	100.0	133	100.0	264	100.0

Source: Field Survey, June, 2011

From Table 8, 95% of the aged from the urban areas as against 18% in the rural areas have access to pipe-borne water, 1.5% from the urban areas as compare to 65.4% from the rural areas uses borehole water, while 3.1% and 16.5% in the urban and rural communities respectively used well water. An average of 56.4% of the aged respondents had access to pipe-borne water, 33.7% had access to borehole and 9.8% had access to well. This indicates that, generally about 90% of the aged had access to relatively potable water (pipe-borne and borehole) which is higher than the 2009 national figure of 57.5% access. This implies that, majority of the aged may not be at risk of water related diseases particularly in the study area. The 16.5% of the people in the rural area who depended on well as their source of drinking water needs to be encouraged to boil the water before drinking it.

3.4.3 Sources of Energy for Cooking

About 51.5% of the aged respondents relied on charcoal for cooking (78.7% and 21.3% in the urban and rural areas respectively) as compared to 52.6% at the national level. Whiles 38.3% relied on firewood, 6.4% and 3.8% depended on gas and electricity respectively for cooking as shown in Table 9. This finding explains that, the energy use of the aged can contribute to deforestation which hinders development..

Table 9: Sources of Energy for Cooking

Community	KMA		BDA		Overall	
Source of energy	F	%	F	%	F	%
Charcoal	107	78.7	29	21.8	136	51.5
Electricity	9	90.0	1	10.0	10	3.8
Gas	11	64.7	6	35.3	17	6.4
Fire wood	4	4.0	97	96.0	101	38.3

Source: Field Survey, June, 2011

3.4.4 Sources of Energy for Lighting

Good lighting is a very important facility for the aged. The study revealed that, 84.5% (48.9% from urban and 51.5% from rural) of the respondents used electricity, 11% used lantern and 4.5% used other sources (such as candle light, "bobo light", firewood and no light). According to the Ghana Living Standard Survey (2008), 79% of households in urban areas in Ghana as against 85.7% in the study area had electricity for lighting, thus, the results of this study places the aged at a better position, comparatively.

Table 10: Sources of Energy for Lightening

Community	KMA		BDA		Overall	
Source of energy	F	%	F	%	F	%
Lantern	16	55.2	13	44.8	29	11.0
Electricity	109	48.9	114	51.1	223	84.5
Others	6	50.0	6	50.0	12	4.5

Source: Field Survey, June, 2011

3.5 The Healthcare Situation of the Aged

This section discusses the health care that is given to the aged who are more susceptible to health problems. About 86.7% of the aged respondents had registered under the NHIS and hence only pay for additional medical charges that is not covered by the NHIS, the remaining 13.3% paid for their own health care (Table 11). About 28.4% of the aged respondents who had registered for NHIS had to pay for their premium because they did not fall within the exemption age group of 70 years and above. The study revealed that, majority of the aged respondents (93.6%) attended the hospital when they are not well (Table 11). About 8% attributed their visit to the hospital to free health care under the NHIS and the provision of comparatively better health care than other health care facilities (71.6%). The 6.5% who did not patronise the hospitals mentioned challenges they encounter when they visit the hospital: which include long waiting time, high cost of health care and medical expenses not covered by the NHIS; these could be one of the driving forces that encourage self- medication.

Tinker in 1984 reported that the aged population is vulnerable/prone to illness and most of them usually have not less than one illness. The research affirmed Tinkler's report; 58% of the aged respondent reported of more than one illness and the other 42% reported of only one. About 3.8% of the Aged from the rural areas as against 0.8% from the urban areas suffered from eye disease. Diabetes and heart related diseases were relatively higher in the rural areas (2.3% and 6.8% respectively) than in the urban areas (0.8% and 4.6% respectively). The reason however could not be readily explained and needs further investigation clinically. Stroke (cerebrovascular accident) was dominant in the urban communities (2.8%) than in the rural communities (1.0%) and this could be due to the strong involvement of the rural folks in activities such as farming, walking long distances to work and farms even at the old age which inadvertently keeps them fit. It thus implies that the aged would need adequate attention in relation to healthcare and other health supporting activities such as appropriate exercises and enough social interactions which will help keep them healthy. Self-medication seems to be a frequent habit among 24.3% of the aged as a result of regular bodily/joint pains. All the aged in both the urban and rural areas access health care as a result of malaria. This finding is not surprising since malaria is the most prevalent disease in the country. There is therefore the need for the aged to be provided with insecticide treated nets to reduce the incidence of malaria. Seeking regular medical care was just one of the means the aged respondents used to sustain their health. They also used other means which is shown in Table 11. The study revealed that 30.3% of the aged respondents exercised to sustain their health which is not very typical of Ghanaians.

Table 11: Health Situation of the Aged

Health issues	KMA		BDA		Overall	
	F	%	F	%	F	%
Type of Health Facility Visited by the Aged						
Hospital/Clinic	122	93.4	125	93.7	247	93.6
Herbal	2	1.6	4	3.0	6	2.3
Others	7	5.1	4	3.3	11	4.2
Total	131	100.0	133	100.0	264	100.0
Reasons for choosing health care facility						
Better Service	103	78.6	86	64.7	189	71.6
Good Proximity	0	0	4	3.0	4	1.5
Affordable	11	8.4	10	7.5	21	8.0
No Reason/Not Sure	17	13.0	33	24.8	50	18.9
Total	131	100.0	133	100.0	264	100.0
Means of paying for health care						
Without Health Insurance	18	13.7	17	12.8	35	13.3
With Health Insurance	113	86.2	116	87.2	229	86.7
Total	131	100.0	133	100.0	264	100.0
Illness mostly reported to health facility						
Malaria	131	10(	133	100	264	100
Diabetes	1	0.8	3	2.3	4	1.5
Rheumatism	2	1.5	1	0.8	3	1.1
Heart Related Diseases	6	4.6	9	6.8	15	5.7
Stroke	4	2.8	1	1.0	5	1.9
Eye Sight	1	0.8	5	3.8	6	2.3
Bodily/Knee/Joint Pain	33	25.0	31	23.5	64	24.3
More Than One Illness	78	59.5	75	56.4	153	58.0
Others	7	5.0	7	5.5	14	5.3
Means of sustaining health						
Regular Exercise	20	15.3	60	45.1	80	30.3
Balanced Diet	6	4.6	5	3.8	11	4.2
Drug/Regular Check-Up	101	77.1	66	49.6	167	63.3
Adequate Rest	2	1.5	2	1.5	4	1.5
Others	2	1.5	0	0	2	0.8
Total	131	100.0	133	100.0	264	100.0

Source: Field Survey, June, 2011

3.6 Means of Breaking Boredom

The study sought to find out what the aged respondents did to keep themselves active, happy and unstressed during their leisure. The research revealed that, 47% visited friends and 23.1% walked about (which also keep their bodies fit) to break boredom. Only 1.5% in both urban and rural areas used club/ association meetings to break boredom; perhaps because their meetings are just once a week/ month. This implies that, the aged are likely to improve their health as they do something to break their boredom.

Table 12: Means of Breaking Boredom

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

Source: Field Survey, June, 2011

3.7 Sources of Support for the Aged

This section discusses the other sources of support that the aged received. These sources included caregivers, religious groups, Department of Social Welfare (DSW) and Compassionate Africa Aged Foundation (CAAF) (a subsidiary of HelpAge Ghana) who give support to the aged.

3.7.1 Support from Caregivers

The study revealed that, averagely 37.9% of the Aged population were staying with their children with 36 % staying with their spouses. Indicating that, majority of the aged, relatively felt more comfortable and secured socially for living with either their spouses or children. However, 22.9 % stayed with their grandchildren or other relatives while 3.2% stayed either alone or with a hired caregiver. The study also revealed that, relatively more aged in the urban communities lived with their children (41.2%) and spouses (36.6%) than those in the rural communities (34.6% and 35.3%) respectively. Majority of the aged in the rural communities (25.6%) than those in the urban (20.2%) lived with their grandchildren/other relatives. Only 2.0% and 4.5% in the urban and rural areas respectively have other source of living arrangement such as hired caregivers as indicated in the Table 13. This could be due to rural-urban migration where most of the able bodied persons left for the urban centres or elsewhere for "greener pastures" leaving their aged parents in the care of their children/other relatives and/or hired caregivers. The study however exposed the fact that hired caregiving is not a common practice culturally as compared to the other ones discussed above. Thus, it could be deduced from the study that people preferred staying with their aged family members rather than hiring caregivers for them though this might have consequences on the family members' job and or their education.

The caregivers play a vital role in the life of the aged. They provide psychosocial and physiological assistance to the elderly such as engaging the aged in conversation to reduce their stress level which could otherwise aggravate their relatively poor health conditions. They again support the aged to move about easily. They also run errands for the aged groups while others in addition to all that, help them to do their household chores and other necessary activities. The absence of these caregivers might not only create uncomfortable situation for the elderly but could also facilitate and accelerate their early pass-on into eternity.

From the study it was revealed that, 40.4% of the caregivers faced challenge of regularity and punctuality to work. Another 23.1% who were still in school complained of interruptions and disruptions in their studies while 28.8% also complained of financial burden upon them as they care for their aged relative in addition to their nuclear family. About 96.2% suggested social support measure while about 80.8% agreed on financial support and another 73.1% also agreed on free health care support as a means of reducing the financial burden on both the aged and the caregivers. Despite these challenges, the caregivers viewed the care of their aged relatives as a moral obligation that is deeply rooted in their customs and traditions.

Table 13: The Caregiver (Direct Social Care) of the Aged

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

Source: Field Survey, June, 2011

3.7.2 Support from Religious Groups

All (100%) of the religious groups gave social support; 70% gave financial support, and 40% paid for the NHIS registration for the aged who cannot afford to pay for the premium and other medical expenses for those who needed it. This support was given based on one's welfare membership in the church (80%), one's commitment to the church (50%) and on regular payment of dues (70%) (Table 14). The members of the religious institutions were also encouraged to give support in the form of money, clothing, food and visitations to the Aged; however, these were not very much reliable.

Table 14: Criteria for Supporting the Aged

Criteria	Frequency	%
Membership of Welfare	8	80
Payment of Dues	7	70
Level of Need	6	60
Level of Commitment	5	50

Source: Field Survey, June 2011

3.7.3 Institutional Support for the Aged

The Department of Social Welfare (DSW) and Compassionate African Aged Foundation (CAAF) were some of the institutions who gave basic care (financial, housing, healthcare and social support) to the Aged.

The major social intervention for the aged identified by the study was the "Senior Citizens' Day" celebration, where on special occasions like the Republic Day, the aged (senior citizens) are invited for a feast. But this is not sufficient enough to relief them of social distress. And even, not all the aged in society either receive invitation or able to make it to that feast. The National Health Insurance Scheme was identified as the major healthcare policy that supports the healthcare needs of the aged but only those aged 70 years and above enjoy free/subsidized NHIS registration/renewal. The availability of health insurance encouraged more aged to seek appropriate medical care.

The study revealed that DSW is the technical and policy implementing agency of the DAs on the issues of welfare of the vulnerable including the aged. The DSW gave financial support through the LEAP programme (targeted mainly at the poor) and housing support through "Aged Home" provision. One of the financial policies being implemented on pilot by DSW is "LEAP" a poverty alleviation programme and from the study only 1% of the aged received such assistance. The criteria for disbursement include income/level of poverty, the nature/state of housing conditions and other deprivations including lack of assets such as land and lastly demography and health including the level of chronic diseases and isolation. Another form of accommodation for the aged managed by DSW is the "aged home" mostly for the aged destitute but has limited space. However, from the study sample, none of the Aged respondents received housing support from any of the institutions. The DSW has been encountering a number of challenges in the implementation of its mandate concerning the aged these include; inadequate funds, personnel and logistics. The main source of funding the Aged support programmes has been the government. The funds are not released on time and when they are released, it is always inadequate. DSW has not been efficient in carrying out activities such as; data collection and analysis, monitoring and evaluation of its programmes and projects because they are usually faced with inadequate personnel. The institution has been unable to employ the required personnel to support its activities because of inadequate funding. Most of the time the institution has to depend on National Service Personnel who barely spend ten months and before they become abreast with the activities of the DSW and issues of the Aged, their time of service would be up for another set to take over, this has hampered the effective data collection and monitoring of activities. Logistical constraints also affect the collection, analysis, storage and retrieval of information for future activities.

SSNIT through its national pension scheme gave financial support to the aged, though to only contributors and in the formal employment sector. CAAF basically supported the aged by performing an advocacy role.

4.0 Recommendations and Conclusions

4.1 Recommendations

Based on the findings, the following recommendations have been made:

- The National Health Insurance Policy of free premium payment for the aged should be reviewed by National Health Insurance Authority (NHIA) to cover 65 years and above to cater for more of the aged.

The NHIA should also consider covering 100% of diseases and most of the essential drugs needed by the aged to reduce the cash payment made.

- The "Aged Fund" in the aged policy should be implemented by the government in collaboration with non-governmental organisations, to support the aged, who are prone or susceptible to health, social, financial and or other challenges that could make them miserable and or destitute. The parties involved would have to encourage the religious groups to contribute to it as their social responsibility to the aged.
- Government in partnership with other NGOs as a policy should establish socio cultural resource centres in the communities or convert community centres into multipurpose use for the aged, to help reduce loneliness/ boredom; and to also serve as a channel for culture and tradition education for the youth who would visit the place.
- The DSW should be well resourced (by government) with personnel, logistics and funds to enable them implement aged policies, programmes and projects. It should again spearhead the monitoring and evaluation of the activities laid out for the aged; ensures their appropriateness and suitability to support the wellbeing of the aged.
- Since the aged depended mainly on traditional extended family structures for social protection, the Department of Social Welfare should build the capacity of family members who are caring for their aged relatives (especially the bedridden ones) to ensure that better services are offered to them. Relatives who decide to care for their aged family members should be given tax relief by the government to reduce the financial burden on them.
- An in-depth research on what government and non-governmental agencies (such as HelpAge Ghana) are doing to improve the wellbeing of the Aged is recommended, as this research focused mainly on the Aged's perception of their wellbeing.

4.2 Conclusion

This research sought to investigate into the basic care (healthcare, housing, social and financial) given to the aged in the Kumasi Metropolis and Bosomtwi District in the Ashanti Region of Ghana. The study revealed that, 63.3% of the aged depended on unsustained or insecure income, such as remittances or gifts from other sources and therefore encountered financial difficulties whenever their sources of income support fail. Only 36.7% of the respondents depend on sustained or secured income (income they have control over) such as pension, return on investments or rent property. Majority of the aged had relatively lower standard of living considering the kind of toilet facility they access and where it is accessed. About 93.2% of the aged used both KVIP (73.1%) and pit latrine (20.1%) toilet facilities, Whiles 80.7% accessed it from the public facility outside their home. The squatting position used affects and worsens their health situation due to the knee and joint pains they suffer from. Self-medication seems to be a frequent habit among 24.3% of the aged as a result of regular bodily/ knee/joint pains. Fifty eight percent of the aged suffered from multiple illnesses; this might be as a result of old age which made them susceptible to illnesses. All the aged had access to health care and 86.7% were registered with the NHIS however, 83% of them used both cash payment and NHIS because certain services and medications are not covered under NHIS.

The caregivers played a very important role in maintaining the social, psychological, financial and health care needs of the aged. Whiles the religious bodies counseled, prayed and visited the aged who are in good standing with the church. Seventy percent of them in addition gave financial support with 40% adding some form of health support. Based on these findings, recommendations have been made to improve the wellbeing of the aged. The true meaning of old age should normally be seen as blessing from God and thus should be free from perpetual illness, misery and poverty. In this regard, policies directed towards the aged must be appropriately implemented to be efficient and effective in achieving its aims.

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