

UNIVERSITY OF CAPE COAST

PROVISION OF SOCIAL SUPPORT FOR THE AGED IN THE CAPE COAST
METROPOLIS

BY

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UNIVERSITY OF CAPE COAST

**PROVISION OF SOCIAL SUPPORT FOR THE AGED IN THE CAPE
COAST METROPOLIS**

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2010

DECLARATION

Candidate' declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university of elsewhere.

Candidate's Signature:..... Date:.....

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Supervisors' declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision laid down by the University of Cape Coast.

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ABSTRACT

With the increasing number of the aged in Ghana, social support for this segment of the population is gradually becoming an issue of great concern. There is debt of research on this. This study is therefore an attempt to provide some information for policy makers towards enhancing planning of better health, social financial support services for the aged to promote their well-being. The descriptive and explanatory survey designs were employed to achieve the objective of the research.

The present study examines the type of social support available for the aged in the Cape Coast Metropolis. It assesses the adequacy or otherwise of such support. Data were gathered in two type of social communities of the five zones of the metropolis. The research focused on the type of social support available, the main providers of the support and how the aged themselves react to the support.

The evidence from the study shows that the informal support system is the most important source of support for the aged. It also found that the provision of the support has gradually shifted from the extended to the nuclear family with daughters of aged providing much more than their sons.

The aged admit that their children could not provide all their needs in the face of the latter's commitment to other responsibilities in the nuclear family. The implication is that government intervention will be necessary to augment the effort of their children, as a way of improving social support.

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DEDICATION

To Edith, Caroline, Amanda, Chelsea and Princess.

TABLE OF CONTENTS

Content	Page
DECLARATION	ii
ABSTRACT	iii
ACKNOWLEDGEMENTS	iv
DEDICATION	v
TABLE OF CONTENTS	vi
LIST OF TABLES	x
LIST OF FIGURES	xi
ACRONYMS	xii
CHAPTER ONE: INTRODUCTION	1
Background to the study	1
The statement of the problem	4
Research questions	5
Objectives of the study	5
Research hypotheses	6
Rationale of the study	7
Scope of the study	7
Limitations	8
Operational definition of terms	8
Organisation of the study	9
CHAPTER TWO: REVIEW OF LITERATURE	11
Introduction	11

Overview of the world's aged population	11
Theoretical issues of the aging population	17
Social support	23
Aging and social support in Ghana	41
The conceptual framework	47
CHAPTER THREE: RESEARCH METHODOLOGY	51
Introduction	51
The study area	51
Research design	55
The study population	56
Sources of data	56
Sampling procedures	57
Research instruments	61
Data collection	62
Actual fieldwork	63
Data processing and analysis	64
Limitation to data collection	65
CHAPTER FOUR: RESULTS AND DISCUSSION	66
Introduction	66
Socio-demographic and economic characteristics	66
Number of children	68
Occupational status	74
Provision of social support for the aged	77

Provision of social support	80
Activities of daily living	85
Testing the research hypotheses	89
Perceptions and reaction to social support	92
Provision of social support for the aged	94
Rating of social support by respondents	95
Improving the social support for the aged	98
CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	106
Introduction	106
Summary	106
Major findings	107
Conclusions	110
Recommendations	111
REFERENCES	116
APPENDICES	122
APPENDIX A: INTERVIEW SCHEDULE FOR THE AGED	122
APPENDIX B: BRAIN STORMING SESSION GUIDE FOR SOURCES AND TYPES OF SOCIAL SUPPORT AVAILABLE FOR MEMBERS OF GHANA PENSIONERS ASSOCIATION OF CAPE COAST	136
APPENDIX C: OBSERVATION GUIDE FOR PHYSICAL APPEARANCE OF RESPONDENTS AND	

THE SITUATION OF THE COMPUND	137
APPENDIX D: RESULTS OF HYPOTHESIS TESTED	138

LIST OF TABLES

Table	Page
1 Localities and their population in the Cape Coast Metropolis [n = 140]	58
2 Distribution of respondents in the study area	60
3 Number of children [n = 140]	69
4 Educational attainment [n = 140]	72
5 Occupational status [n = 140]	74
6 Performance of activities of daily living [n = 140]	86
7 Payment of medical bills [n = 140]	89
8 Satisfaction of quality of accommodation [n = 140]	90
9 Satisfaction of provision of means for meals [n = 140]	91
10 Contributions of the aged towards the upkeep of the home [n = 140]	93
11 Contributions of the aged in the community [n = 140]	94
12 Rating of social support by respondents [n = 140]	95
13 Improving the social for the aged [n = 140]	99

LIST OF FIGURES

Figure		Page
1	Social support for the aged	49
2	Cape Coast Metropolitan Map showing the study areas	54
3	Aged-sex distribution of the aged	67

ACRONYMS

ADL	-	Activities of Daily Living
AIDS	-	Acquired Immune Deficiency Syndrome
CBO	-	Community Based Organisation
CCP/QPP	-	Canada Compulsory Pension/Quebec Pension Plan
GIS	-	Guaranteed Income Supplement
GNAT	-	Ghana National Association of Teachers
MOFA	-	Ministry of Food and Agriculture
NCCE	-	National Commission for Civic Education
NFED	-	Non-Formal Education Division
NGO	-	Non-Governmental Organisation
OAS	-	Old Age Security
OLA	-	Our Lady of Apostle
SAR	-	Special Administrative Region
SPSS	-	Statistical Product for Service Solution
SSNIT	-	Social Security and National Insurance Trust
UN	-	United Nations
UNESC	-	United Nations Economic and Social Council
UNFPA	-	United Nations Population Fund
USA	-	United States of America

CHAPTER ONE

INTRODUCTION

Background to the study

Aging is a natural process that affects every living organism. As human beings, we are aging every day (Help Age International, 2001). Improved medication, good dieting, among others, may usher many young people into old age. There is, therefore, the possibility of a gradual demographic shift towards an aging population in all countries (UNFPA, 2000).

Owing to their physical weakness, aged persons have different needs and priorities, which need maximum attention. Their rights, needs and contributions need to be well understood, especially when they cannot cope with their situation in isolation. Planning for better health, social and financial support services for the aged, therefore, is a necessity (Atchley, 1989). It is essential, particularly to provide food, clothing, accommodation, healthcare, transportation, information and companionship through socialization. This is to help maintain their psychological, social and physical integrity. It will also enable these aged persons to remain healthy, independent and productive (Cantor, 1990; Brown, 1999).

Traditionally, caring for the aged, the world over, is supposed to be the responsibility of friends, neighbours and members of communities such as a village or a clan. In many countries, it is supported by special institutions (Tout,

1990). In Indonesia, for instance the Biro Manula Organisation has set up homecare centres, for the aged. Midday meals are served and attention given to medical care, house repairs, clothing, recreation, opportunities for self employment, religious counselling and funeral insurance. Also, help age organisations in South Korea hold social events, often tea parties, where aged persons meet and socialize, sometimes even forging matrimony (Tout, 1990). In the United States, the Area Agency on Aging unites local organisations to meet the needs of local aged persons (Atchley, 1989). The Undujaju society of Kenya offers weekly financial allowances plus a cup of tea and bread. The society also assists those without relatives to find a home help. Zimbabwe's Dete Old Age Association also offers retired miners accommodation, medical care and employment (Tout, 1990).

In Ghana, care for the aged is part of the socio-cultural custom. In both traditional and modern Ghanaian society, old age is considered to be dignified. The aged, therefore, deserve honour, respect and sympathy. This compels the young to look after them with all the needed tenderness. A child cannot neglect this duty without losing face considerably. There is a popular saying among the Akans that 'when someone has looked after you to grow your teeth, you should also look after the person to lose his/her teeth' (Brown, 2000).

However, social change has gradually eroded and broken down the extended family support system. Formal education, urbanization and improved technology, with their attendant economic and financial constraints, have placed emphasis on the care of spouses and children or the introduction of the nuclear

family system at the expense of the extended family. Children who are supposed to look after their aged parents sometimes have to travel away from home to work or search of jobs. This trend of immigration is mostly from rural to urban areas. The result is that the young and energetic children who could work on farms to provide food and other needs for their aged parents are not available. The aged left in the rural areas do not have the strength and energy to work to maintain or increase food productions therefore, little is left to support them. In the urban areas, some of the youth remain unemployed because few or no job opportunities exist. Again, some do not have the requisite skills or qualifications to be employed. Those who are able to secure jobs may be saddled with its responsibility of caring for their immediate children and spouses needs. The reality therefore, is that a number of them are unable to remit their aged parents left behind. Some of the aged parents who stay with their children in urban areas may not receive enough support because the children may not be in well paid jobs. This has, as a result, left little for the aged, especially those who have lost their spouses and did not care for their children when young, are left with no social support. The Department of Social Welfare and Community Development does not have enough resources to provide the needs of the aged. The situation has become so grave that Non-Government Organisations (NGOs) have intervened to save it. One of such NGOs is Help Aged Ghana, an affiliate of Help Age International, which was established in Ghana in 1988. The provision of social support for the aged continues to be a shared responsibility among families,

friends, neighbours and members of a collectivity as well as emerging institutions, organisations and agencies.

The statement of the problem

Traditionally, kings in Ghana have an obligation for the caring of one another, especially the sick and the aged. These obligations include the provision of food, clothing, healthcare and shelter (Brown, 2000). Most Ghanaians are still willing to take responsibility for their aged parents and relatives. However, social change, that accompanied modernization, has brought pressure to bear on families. In addition, formal education, urbanization and the introduction of western cultural values, which have made the nuclear family more important and preferable, tend to undermine the traditional values even further (Apt, 1992).

Furthermore, there is no explicit government policy to prepare the worker to cope with old age. As a result, one attains the age of 60 with little or no knowledge about how to cope with the situation. Managing the situation, therefore, becomes difficult for some of the aged themselves as well as their families. It is also not clear whether organized social support services are available to augment the effort of the traditional system in Ghana.

In Cape Coast, the study area, one identifies two main groups of the aged. On the one hand, are those who appear in shabby clothes looking weak and pale, with a few asking for alms in cash or in kind on the streets, markets and workplaces. This creates an impression of isolation and neglect. On the other hand, are others who look decent, well fed and quite healthy, thus creating an

impression of good care and comfort at home. The research, therefore, sought to examine the extent of such problems or difficulties faced by some of the aged in respect of good care. It will also examine factors that account for the deplorable situations of such aged persons.

Research questions

It is always necessary to identify a problem in order to give meaning and direction to a research activity. One effective way of addressing this problem is by trying to pose certain questions which have been identified. This has the tendency of assisting the researcher to establish a focus, thus stimulating effective research to achieve the desired results. In this respect, the following questions will be investigated:

- What types of social support systems are available to the aged?
- Are there any variations in the available support?
- What are the perceptions and reactions of the aged to the social support system available?
- How adequate is the available social support for the aged in the Metropolis?

Objectives of the study

The general objective was to examine the social support system available to the aged in the Cape Coast Metropolis. The specific objectives were to:

- Identify the types(s) of social support available for the aged in the Cape Coast Metropolis;
- Explain the variations, if any, of the available social support systems;
- Investigate if providers offer any social support to the aged;
- Assess the perceptions and reactions of the aged to available social support and its adequacy; and
- Make recommendations for policy interventions.

Research hypotheses

Based on the questions raised the following hypotheses were formulated:

- H₀. The aged whose medical bills are paid by their children are more likely to be dissatisfied with their payment arrangements than the aged whose medical bills are paid by others.
- H₁. The aged whose medical bills are paid by their children are more likely to be satisfied with their payment arrangements than the aged whose medical bills are paid by others.
- H₀. The aged who continue to live with children are more likely to be dissatisfied with the quality of their accommodation than the aged who are living with others.
- H₁. The aged who continue to live with children are more likely to be satisfied with the quality of their accommodation than the aged who are living with others.

H₀. The aged who receive support for meals from their children are more likely to be dissatisfied with their meals arrangements than those who do not receive support from their children.

H₁. The aged who receive support for meals from their children are more likely to be satisfied with their meals arrangements than those who do not receive support from their children.

Rationale of the study

An investigation into the social support system of the aged is not only timely, but appropriate, given that the aged persons form an important segment of the nation's population. Thus, the results of this study will contribute to the literature on population, health and welfare. It will also serve as a useful source of document to academics, researchers and students who will carry out future research in the study area. Additionally, results of the study could inform national and local policy makers and non-governmental organisations NGOs interested in the welfare of the aged and vulnerable in society.

Scope of the study

The research focused on social support available for the aged in the Cape Coast Metropolis of the Central Region of Ghana by targeting aged persons who were 60 years and above. It sought to investigate the type of support available, those who provided the support as well as the reactions and perceptions of the aged towards the support. Finally, the study sought from the target population

how social support could be improved to better their well-being. Regarding the time dimension, the study focused on the period from 1992 to 2002.

Limitations

The study is an individual research activity which was time-bound and with limited financial recourses. As a result, it could not review all relevant literature available in the subject area of interest; again, the study interviewed a limited number of 140 respondents without extending same to care providers such as family heads and other members. However, the methodology used provided a fair view of the situation on the ground. These limitations notwithstanding, the result, conclusions and recommendations from this study will be a relevant contribution to the subject of aging, but the findings must be interpreted in its context.

Operational definition of terms

The aged

For the purposes of this study, chronological age of 60 years and above will be considered as the definition for the aged. The choice is viewed against the background of the fact that 60 years is the age at which workers in the formal sector in Ghana retire from active service. At this age, they become eligible for full retirement benefits from social security and pension schemes (Social Security Law 247, 1991).

Social support

Social support is defined in this study as the mobilization of interpersonal resources to cope with the problem of aging. This includes; cash remittances, feeding, clothing, information flow, accommodation, medication and visit when sick.

Nuclear family

A father, mother and children make up a unit to live together as a nuclear family.

Extended family

Two or more nuclear families come together to form a more complex family to live together as an extended family.

Organisation of the study

The thesis is organised into five chapters. Chapter One discusses the introduction to the study. The main highlights of this chapter include the background to the study, statement of the problem, objectives, research questions, hypotheses, the rationale of the study, scope of the study, limitations, operational definition of terms and the organisation of the thesis.

Chapter Two focuses on the literature review of aging and social support systems and the conceptual overview of the support. It discusses an overview of the world's aged population, theoretical issues of the aging population, the

composition of aging and social support in Ghana and ends with the conceptual framework used in the study. The methodology is discussed in Chapter Three. This chapter begins with an introduction and continues further to discuss the profile of the study area. It also focuses on the research design, the study population, sources of data, data collection, actual fieldwork, data processing and analysis and limitation to data collection.

Results and discussions of the research activity are presented in chapter four. These involve the analysis of socio-economic characteristics of respondents in relation to available social support, analysis of the perceptions, reactions and rating of social support by respondents and the improvement of available social support systems for promoting and sustaining the well-being of the aged. Finally, Chapter Five provides the summary, conclusions and recommendations from the study.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This chapter provides an overview of the world's aging population and its related theoretical issues. It attempts to explain what social support is and relates aging to social support in Ghana. The chapter ends with the explanation of the conceptual framework relevant in the provision of social support for the aged.

Overview of the world's aged population

In the past, the aged were few in number and were considered unique and remarkable rather than burdensome. A large proportion of the aged in the society today is, thus, a very recent development (Woodruff and Birren, 1983). The aging phenomenon received prominence as far back as the 19th Century when the Germans set age 65 as the criterion of aging for the world's first modern social security system in 1883 (Sullivan, et al, 1980).

According to United Nations Population Fund (UNFPA,2000), people live longer and healthier lives from infancy to old age today because of basic sanitation, clean drinking water and modern health care. Accordingly, the drop in mortality, combined with longevity, is a significant part of the story behind the fast population growth in recent decades. The World Population Reference

Bureau of the United Nations (2001) puts the average life expectancy of males and females at 64 and 68 years respectively. This gives an average life expectancy as 66 years nationwide.

However, Japan's life expectancy of 82 years is the highest in the world today. In some exceptional situations the aged may live longer beyond 82 years. In Italy, for instance, a remarkable number of Sardinia's 1.6 million inhabitants live through the century. Some 135 people per million live to see their 100th birthday in this city (The Ghanaian Mirror, January 2001).

Although people are living longer, large variations also remain. Life expectancy at birth over the last five decades increased by almost 20 years globally from 46.5 years during 1950-1955 to 66 years during 2000-2005. Also, on the average, the gain in life expectancy at birth was 23.1 years in the less developed region and 9.4 years in the more developed regions (UN, 2001).

While no remarkable variations may exist within the developed regions, with a range of 11 years, from 71 years in Latvia to 82 in Japan, the situation within the less developed regions appears to be quite different. In some countries and parts of the less developed regions, such as Israel, Martinique and Macao Special Administrative Region (SAR) of China, life expectancy is estimated at about 79 years. However, in such countries as Botswana, Mozambique and Swaziland, it does not go beyond 39 years, thus bringing the range of life expectancy to 40 years. In many countries, most of which are in less developed regions, the spread of HIV/ AIDS partly accounts for the low level of life expectancy (UN, 2001).

Life expectancy is projected to increase to 76 years globally over the next 50 years. The gap in the life expectancy among regions will tend to decrease when mortality becomes more concentrated at old ages of the population. Life expectancy is expected to be 82 years in the more developed regions and 75 years in the less developed regions. So, an interregional gap of about 7 years is expected by 2045 -2050, as compared to approximately 9 years in the period of 2025 – 2030. More people will, therefore, survive to older ages. Hence, in proportional terms, gains in life expectancy are expected to be higher at older ages (UN, 2001).

One important feature of global life expectancy is that the female/male life expectancy at birth is widened. Although for a small number of countries cultural factors have contributed to lower female life expectancy, reduction in mortality generally has been higher among females than males in all age groups. In view of this, the female advantage in life expectancy at birth increased to 4.2 from 2.7 years world-wide over the past 50 years. It is projected to increase slightly to 4.8 years globally in the next 50 years (UN, 2001). In the more developed region, where women outlive men by 7.4 years, the gender gap is expected gradually to decline to 6.1 years over the next half century. In the less developed regions, where the gender gap has been significantly smaller, it is expected to continue to increase from the current 3.2 years to 4.4 years by the middle of the century (UN, 2002).

In Japan, the near 85 years life expectancy at birth for women is currently the highest in the world. In 30 other countries, female life expectancy at birth now exceeds 80 years. This includes eight countries and areas from the less developed

regions, namely: Hong Kong, Israel, Macao and Singapore in Asia, Guadeloupe, Martinique and Puerto Rico in the Caribbean, and French Guinea in Latin America. Over the next 50 years, female life expectancy at birth is expected to surpass 92 years in Japan and 85 years in 26 other countries. It is also projected that 59 percent of the world's female newborns will survive to attain 80 years by 2050 as against the current 41 percent. However, among 20 countries, most of which are in West and East Africa, not more than 40 percent of female newborns will survive to attain 80 years by 2050 (UN, 2002).

The number of aged persons has tripled over the last 50 years. These numbers will more than triple again over the next 50 years (UN, 2002). Globally, one in every 12 persons was at least 60 years of age in 1950. By the year 2000, this had increased to one in every 10 persons. By the year 2005, more than one in every 5 persons was projected to be 60 years or above world-wide (UN, 2001).

In 1950, there were 205 million persons aged 60 years or older. During that period only 3 countries had more than 10 million people 60 years or older: China (42 million), India (20 million) and the United States of America (20 million). After fifty years, the number has increased three times to 606 million. So, the number of countries with more than 10 million older people increased from 3 to 12. Five of such countries had more than 20 million older people. They include: China (129 million); India (77 million); the United States of America (46 million); Japan (30 million); and the Russian Federation (27 million). Over the first half of the 21st Century, the global population of 60 years and above is

projected to increase by more than three times to nearly 2 billion in 2050 (UN, 2002).

In their contribution to the literature, Letha and Scanzoni (1988) observed that at the beginning of the 20th Century, the United States of America, for instance, saw a drastic increase of its aged population. In 1900, there were 3 million persons aged 65 years and older. By 1950, the figure had quadrupled to over 12 million, and by the 1980 Census, this doubled again to over 25 million. According to Atchley (1989), the Census Bureau predicted in 1985 that the aged segment of the United States population will number 35 million by 2000 and over 67 million by 2050. There was therefore, a growth rate of 4.1 percent in 1900 and over 11 percent in 1980. So, not only has the population of the aged dramatically grown in terms of numbers, but relatively, the size has almost tripled. According to Gilles (1988), in 1900, only one North American out of 25 was over 65 years of age. Today, it is closer to one out of eight. Marshall (1998) also observed that proportionately, the population of developed countries at 65 years and above, such as Japan, Germany, Britain and United States, has increased from 7.9 percent in 1950 to 13.5 percent in 1998 and expected to be 24 percent or more by 2050.

In furtherance to this, Atchley, (1989) also noted more dramatic developments. According to him, the aged population of the most rapidly aging countries, such as Germany and Japan, will exceed 42 percent of the population by 2050, attributing this development to low fertility and mortality rates.

In another development, the United Nations Economic and Social Council (UNESCO, 1989) observed that developing countries are witnessing an

unprecedented growth in their aged population. It indicates that in 1950, out of the world's total population of 200 million of aged persons, half of this number lived in developing countries.

Brown (1992) also adds that irrespective of their youthful population, the developing countries' increasing trend of the elderly population was quite significant in 1975 and will continue to 2025. He further indicates that in 1975 developing countries were responsible for 52 percent of the total 346 million aged persons of the world who were 60 years and above. By 2025, the figure is expected to increase to not less than 72 percent, representing an absolute increase from 180 to 808 million aged persons from 1975 to 2025.

In another contribution, Tout (1990) indicates that the last two decades of the 20th Century saw the aged population of 60 years and above in sub-Saharan Africa increasing by almost 82 percent.

Significantly, the aged population is also growing faster than the total world population with the difference in growth rates widening with time. Between 1950 and 1955, the global annual average rate of increase in the number of persons 60 years or over, estimated at about 1.8 percent, was almost the same for the annual rate of the world's total population. However, the current growth rate of the older population, estimated at 1.9 percent is significantly higher than the 1.2 percent growth rate of the world's total population. In the not too distant future, the difference between the two rates is expected to widen when the baby boom generation begins to attain older ages in many parts of the world (UN, 2001).

Another important statistical observation is that there is a slight majority of females, as compared with males, of 60 years and above. It is further observed that the sex ratio will continue within 1 percent through 2025 in spite of variations between countries, regions of countries and between urban and rural environments (Brown, 1999).

Theoretical issues of the aging population

The issue of the world's aging population has been of interest in recent years because of the rapid growth of the elderly and the increase in demand for social support for them. This has led to the presentation of various theories explaining how to cope or manage the aging process. These include activity, disengagement and modernisation theories.

Activity theory

Activity theory states that the maintenance of a high level of activities in the face of lost roles and activities makes the aged adopt a substitute attitude (Cavan, Burgess, Goldhamer & Havighurst, 1949). In their study on adjustment to aging among white middle class men and women over 60 years of age in Chicago, U.S.A., they maintained that high life satisfaction in old age is achieved by retaining middle-age activity levels. They observed that people who continued to lead active and productive lives remained well-adjusted in old age, but rather, poor adjustment was correlated with lack of activity. When people lose certain roles or the capacity to perform certain activities, an obvious way is to adopt a

substitute role. This implies that aged persons want to maintain a high level of activity. How feasible this is, depends on a number of factors. First, a substitute must be available. Second, the person must have the physical and mental capacity to perform a substitute role or activity effectively. Finally, the person must want a substitute (Cavan et al, 1949).

Substitutes are often not readily available. Retired people cannot easily find new jobs, sometimes because of the continuous decline of their physical and mental capacities (widows cannot easily find new mates). If role or activities are lost through income or physical decline, then substitution is not a readily available strategy. Thus, although substitution may be a feasible and attractive way to cope with loss early in life, with age, it becomes increasingly more difficult to put in practice. As a result, the aged continue to lose social status with time. This makes them more dependent hence, the demand for social support to improve and sustain their well being.

Disengagement theory

This theory argues that as one is aging there is a natural and inevitable mutual withdrawal, resulting in decreasing interaction between an aging person and others in the social system one belongs to (Quadagno, 2002). Cumming and Henry (1961) indicate that disengagement occurs when people withdraw from roles or activities and reduce their activity level or sense of involvement. Based on their works in Kansas City in the U.S.A during the 1950s, they brought the issue of disengagement into sharp focus. They theorized that turning inward,

typical of aging persons, produce a natural and normal withdrawal from social roles and activities, increases pre-occupation with self, and decreases involvement with others. They also emphasized that individual disengagement was conceived as primarily a psychological process involving withdrawal of interest and commitment.

According to them, social withdrawal was as consequence of individual disengagement, coupled with society's withdrawal of opportunities and interest in aged persons' contributions. This theory caused a flurry of research, because, in positing the "normality" of withdrawal, it challenged the conventional wisdom that keeping active was the best way to deal with aging. Now, after about 34 years of studies about disengagement, it is observed that the phenomenon is neither natural nor inevitable and that most cases of disengagement result from a lack of opportunities for continued involvement (Atchley, 1989).

Disengagement theory went astray at many points (Atchley, 1989). Because it was based on observations of aged persons in the 1950s, it dealt with people who typically were trying to adapt to a much more adverse situation, particularly in terms of retirement income and public attitudes towards the aged. Unless they can find a substitute, these people are forced to disengage. Consolidation may also not be a satisfactory solution if the lost activity was extremely important to the person and if the remaining activities, though perhaps plentiful, are not meaningful. Sometimes, some cultural values which place premium on the aged may not permit them to engage in certain activities which

might be the only ones available. This may force the aged to disengage (Atchley, 1989).

Modernization theory

To the modernisation theory, changes accompanying industrialisation inevitably diminish the status of the aged (Cowgill, 1974). The central thesis of modernisation of societies is the evolution of society from the rural and agrarian social and economic systems to urban and industrial ones. This situation also changed the positions that aged persons occupy in the society. The direction of change is usually assumed to be for the worse where the aged lose their advantaged status (Atchley, 1989).

In his contribution, Cottrell (1960) viewed modernisation as a result of the growing use of fossil fuels and technology to increase human productivity. To him, the most significant aspect of the historical shift from agrarian to high-energy industrial forms of production was the effects of modernisation of society. Agrarian societies revolved around the village, which in itself was a collection of families. The power of aged persons in the agrarian system stemmed from their positions as heads of families. This, in turn, admitted them to the council of elders who ran the community. As keepers of knowledge and tradition, decision-making in agrarian societies was the preserve of the aged. Accordingly, heads of families made decisions in all realms of life, including political, economic, religious and social issues.

Owing to the increasing use of water, steam, wind and electric power, the demand for labour for production fell drastically. Also, production depended more on technology than on land. This stemmed from the growing knowledge of science and technical capabilities which were beyond the capacity of any one person to know it all. As a result, the value of the aged as keeper of knowledge diminished (Cottrell, 1960).

In advancing the notion of the emergence of a new egalitarian society, Cottrell (1960) held the view that the traditional hierarchical authority had been undercut. As controllers of the traditional society, the aged subsequently came under severe attack by those who advocated for the change of the old system. The aged, therefore, lost their advantaged position because they represented an outdated social order.

Cowgill (1972) felt that several factors, associated with modernization, combined to reduce the desirability of the aged in the society. Viewed against a lower demand for workers as a result of increase in the use of technology, they precipitated a competition between the aged and the young for jobs. Also, the value of experience and practical skills, which the aged depend mainly to offset their relatively lack of physical dexterity, fell due to the increasing number of new kinds of jobs.

Furthermore, Cowgill (1972) argued that retirement lowered the value of the aged because it was assumed that they were no longer capable and were a less desirable income category. He also indicated that rapid social change and child-centred education outside the family made obsolete much of the knowledge that

had formerly been considered a foundation of esteem for the aged. Finally, urbanisation, according to Cowgill (1972), often left the aged behind causing them to be seen as “backward”. He considered that it was for those reasons that much of the power and prestige of the aged were lost to the process of modernisation.

Some analysts contend that the decline in the social position of the aged occurred before many of the effects cited by Cowgill (1972) became obvious. In this case, the aspects of modernisation cited by Cowgill (1972) could not be responsible for lowering the status of the aged. This does not necessarily discredit modernisation as the primary cause of the position of the aged. To consider modernisation first and foremost as a revolution of ideas, one might then see both industrialisation and the changing position of the aged as being the cause of the shift in ideas. The central argument here is that, modernisation is not merely the result of technological advancement or bureaucracy. Modernisation also involves the improvement of cultural values and new ways of thinking. This should be present if social, cultural and economic organisations are to thrive (Cowgill, 1972).

There seem to be linkages among the three theories mentioned above. In adapting to lost roles or activities, the aged may look for a substitute. When that fails, he may be compelled to consolidate what remains of their activity. However, consolidation may depend on the importance that the aged in question attaches to such activities. If such activities seem meaningless, the aged may withdraw and, therefore, disengage. Opportunities to replace lost roles and

activities determine the availability of substitution. Norms about what is acceptable or proper for older people affect what friends and relatives advise in coping with lost roles. Consolidation may be the most common outcome because it preserves continuity both for the individual and for those who seem to be the most inclusive. It also allows the greatest flexibility. Clark and Anderson (1967)) refer to it as the “path of least resistance”. The extent of disengagement may depend very much on how the aged feel threatened by their environment. Ultimately, the balance among consolidation, substitution and disengagement depends very much on health. Good health is a prerequisite for the consolidation and substitution approaches to coping with role and activity losses. Furthermore, the aged who are in poor health are much more likely to be forced into disengagement.

Social support

The literature tends to agree on two different modes of social support; tangible and intangible support. Tangible support refers to the provision of such concrete physical assistance such as foods, cash, material goods, labour and time. Intangible support modules informational and emotional support. Informational support is provided through advice, guidance counselling and directives on problems, including health and wellbeing. Emotional support includes listening and providing advice and moral support on health and other problems such as assistance or help given to the aged by children, family members, friends and the general public to maintain and improve the well being of the aged. The changing

demographics, the world over, is influencing the perceptions of the elderly and answers to the questions of responsibility for a country's elderly; especially the frail, the impaired and the dependent (Kosberg, 1994).

In most countries of the world, historical evidence shows that family care of the aged has been the main method by which the needs of the aged have been met (Kosberg, 1994). Family care has indeed been supported often by tradition based upon moral and religious considerations. However, family care provision cannot be viewed as a panacea (Kosberg, 1994). For a variety of psychological, physical or economic reasons, family members may be ill-suited and inappropriate for care giving responsibilities. Again, for other responsibilities at home or in employment, family members may be unable to provide care. Some aged have no family members. Some families may be unavailable or live great distances away from home. Also, some family members may not want to provide care to an aged relative for many reasons (Kosberg, 1994).

As a result, there is often the need for mechanisms, other than the individual or family, to provide needed assistance to the aged in a country. The provision, whether financial, psychological or physical, can come from public or private sector. Public resources can be provided by village, towns, cities or other local communities; by districts or regions; or by national or federal governments. Private resources can be based upon religious, fraternal, tribal, ethnic or other such characteristics. Countries can of course reflect, and often do a combination of privately or publicly sponsored resources for those in need (Kosberg, 1994).

Only in welfare states or through universal programmes are resources provided for all aged on the basis of their chronological age. More often, eligibility criteria must be met to receive programmes, services and benefits. The major criteria used to determine eligibility are “need”. This might be based upon economic, health and psychosocial conditions. Also, vulnerability or high risk related not only to the present condition of aged persons but also to a high probability that adversity will occur to them are other considerations (Kosberg, 1994).

Different countries reflect a range of mechanisms for the care of the aged and an array of combinations of auspices of, and eligibility criteria for, resources for the aged, considering where and when they exit. Efforts to describe and compare services for the aged in different countries have existed for many years according to Kosberg (1994). These services include income maintenance and employment, health care, housing resources, supportive services, leisure-time resources, advocacy and protection. A few instances of methods used by some countries in the provision of these services will be relevant.

Income maintenance and employment

In this section information on income security for aged persons are given. This includes attention to the existence, eligibility and use of public income security programmes and policies, private retirement benefits and pension and financial assistance programmes.

Canada has a three tier retirement income system. In this country, the aged (65 years and above) receive income primarily from government transfer payments. Other sources include private pensions and own investments. The Old Age Security (OAS) is the basic universal benefit to which all individuals over 65 years who have been resident in Canada for 10 years are entitled. Full benefits are available only to those who have stayed in Canada 40 years after the age of 18. This taxable scheme is supplemented by an additional allowance, the Guaranteed Income Supplement (GIS) which is not taxable. In this scheme, individuals whose cash income is either only OAS or minimal from other source are entitled, to the maximum GIS or a portion. Six out of 10 provinces and two territories provide other income supplements to those senior citizens who have only OAS and GIS as sources of income. The federal GIS benefit tends to pay proportionately more to a senior living alone. Provincial “top-up” programmes do not reduce support levels for married persons (Marshall and Wigdor, 1994:68-70).

Canada has a second tier in the retirement income system. This is a compulsory, contributory pension plan known as the Canada/Quebec Pension Plan (CCP/QPP). Every member of the paid work force must contribute to this plan. The two plans (Canada and Quebec) have essentially the same features. Senior citizens at retirement receive a pension equivalent to 25 percent of their average annual lifetime earnings. This is adjusted each year in line with increases in the Consumer Price Index. Contributors to both plans have the option of retiring at any time between the ages of 60 and 70. Where a contributor retires before age 65, the benefit is reduced by 5 percent for each month before the

retiree attains 65 years. Where the contributor retires between the ages 65 and 70, it is increased by the same formula (Marshall and Wigdor, 1994:68-70).

The third tier of the retirement income system is income received from private pension plans. During their working years, employees contribute to a plan, as does the employer. Vesting then takes place after two years of employment and 25 years of age. However, private pension system does not seem portable. Only about half of all Canadians have access to pension coverage at work. Figures available for 1986 show that 56 percent of men and 44 percent of women employed full-time were covered by occupational pension plans. In 1986, only 10.5 percent of the income of women and 20.1 percent of the income of men over the age of 65 came from private pension plan. Some plans similar to CCP/QPP also pay survivor's benefits and disability allowances (Marshall & Wigdor, 1994:68-71).

Employment

South Korea has five major income maintenance programmes for aged persons (65 years and above). This includes public pension, public assistance, retirement benefits, discount services and tax exemptions and job placement (Sung, 1994). The public pensions known as the National Pension Programme started in 1988. This was established by the National Welfare Pension Act, 1973 and the National Pension Act. This national programme covers all workers including self employed, farmers and domestic workers aged 18-60 who are not covered by special pension programmes designed for three occupation groups

including government employees, military personnel and private school and university teachers. Employees of workplaces with five or more full-time workers are eligible to participate in this programme. The programme provides old-age pensions, invalidity pension and survivor pensions. The old-age pension is the major benefit under the programme. To be eligible to participate one must have had a membership for 20 years or more. Those who do not meet this condition are given a lump-sum refund. Contributions to the programme are made from the employee's wages and the employer's liability (Sung, 1994).

The retirement programme was established by the country's Labour Standard Act, 1953. It provides supplementary income for the aged. It is the only income maintenance measure for workers in preparation for their retirement. Those in a workplace with 10 or more full-time workers are eligible for this retirement benefit (Sung, 1994:358-359).

Public assistance programmes for the aged started in 1961, when the Livelihood Protection Act (Saenghwal-Boho Bub) was promulgated. Aged persons who are poor (as judged by the means test) and do not have a legally responsible supporter are entitled to this public assistance. These include cash allowance, medical aids, relief aids, funeral assistance, public nursing home care and tuition for children in school. The types and amount of benefits vary by specific sub programme: a home protection, institutional protection and self-reliance protection. The programme is a restricted public provision for which eligibility requirements are strictly enforced. The central government contributes 80 percent of the programme budget and local government contributes the rest.

Despite the fairly rapid expansion of the Programme, the support level is still very low (Sung, 1994:359).

South Korea also provides cash allowance for senior citizens in compliance with Senior Citizens Welfare Act, 1991(Article 13: Allowance for the aged). Beneficiaries are aged of low-income category, aged who maintain an independent household separately from adult children, who are financially disadvantaged and without a legal or obligatory supporter, and those who are in an institution. Also, discount services are one of the special treatments for the aged, as stipulated in the Senior Citizens' Welfare Act (Article 10: Preferential Treatment for Aged Persons). Started in 1980, these services provide aged persons 65 and above with free fares for subway and ferry boat rides and free admission to public parks, gardens, temples, public theatres and museums. The real road system however provides only a 50 percent discount. The aged also receive 12 free bus tokens monthly from private bus companies for bus rides. However, services provided by private sources including hair services, public baths, movie house among others are not fully covered (Sung, 1994).

To reward and encourage adult children to care for their aged parents (55 years and above for mothers), the government has instituted partial exemption of inheritance tax and a tax exemption for an amount stipulated under the Income Tax Law (Article 66). Also government employees who are live with their parents aged 60 and above (mothers 55 and above) receive a monthly allowance stipulated by the law. For those who have been living with their parents or

spouse's parents for more than two years, several large banks provide low interest loans for construction, purchase, and repair of their own houses (Sung, 1994).

The employed aged persons are engaged in various industries. This include farming and fishing (60.4%), wholesale and retail restaurants and hotels (13.7%), manufacturing (9.1%), private business (8.3%), construction (3.9%), financial, insurance and real estate (3.2%), transportation, storage and communication (1.2%) and utilities (0.1%). According to Kosberg (1994), this statistics was reported by Lee (1992). The report further indicates that of all employed aged persons, 77 percent wish to continue being employed and of all those currently unemployed, 41 percent will like to find work. Both the public and private sectors have developed programmes for job training and placement of aged persons who are willing to work (Kosberg, 1994).

The South Korean Senior Citizen Employment Promotion Act was promulgated in 1991. The principal legislative requirement was that the Ministry of Labour establishes community employment programme for low-income aged persons who wanted to work. To encourage industry to hire the services of older workers, the Ministry stipulated standard employment regulations under the Employment Promotion Act. Under these laws and regulations, an employer is advised to employ a certain ratio of aged workers. An employer who employs aged workers above the recommended ratio is entitled tax exemptions or a tax reduction, according to the Tax Exemption Law (Sung, 1994:360-361).

Health care services

Health needs are major pre-requisite for longevity and comfort among all humans including the aged. It behoves both public and private sectors of countries to make meaningful and sustained contribution towards the provision of better health care services. This is to ensure the well-being of citizens especially the elderly. In this area, attention is given to general healthcare system available, financial arrangement of healthcare and the existence of acute and chronic care services. It further explains hospital, clinic, hospice care and other health care resources used and characteristics of institutions for the aged. Home-based health care services are also explained. In the U.S.A, a nationwide health insurance programme known as Medicare is operated for the aged. Also available, is a public assistance programme called Medicaid.

Medicare established in 1965 consists of two sub-programmes. Part A is a mandatory hospital insurance and Part B, a supplementary out-patient Medicare insurance which is optional. Part A pays for all hospital expenses during the first 60 days of reported illness. From 61 to 90 days, the patient is responsible for a co-insurance payment of 25 percent of the hospital's daily cost. Where more than 90 days may be needed in a single benefit period, the patient may utilize a lifetime reserve of 60 days, but the co-insurance amount increases to 50 percent of a hospital's daily bill. Medicare also covers up to 100 days of skilled nursing in a long-term care facility for purposes of post hospital rehabilitation only. After the first 20 days, a co-insurance rate stipulated by the programme is borne by the patient. Also, home health care is reimbursed on a time-limited and intermittent

basis for similar rehabilitation purposes. Medicare also pays fully for hospice care up to 210 days. This includes aged determined to be terminally ill and with a life expectancy of six months or less (Monk, 1994). Medicare Part B pays 80 percent of physicians' outpatient services charges, laboratory and diagnostic tests, and ambulance services, and outpatient services at the hospital. The 20 percent of total cost is borne by the elderly themselves.

Functionally impaired and physically or mentally dependent aged enjoy long-term care services in nursing homes, community-based settings such as day-care programmes or patient's own home. All these facilities must be certified by the Medicare programmes. Nursing home care ranges from highly skilled nursing facilities to lower levels of nursing care called intermediate or custodial care. The lower level type does not qualify for Medicare re-imburement since it does not lead to short-term rehabilitation. Medicaid, however, takes care of this facility. This programme takes fiscal responsibility of only patients who show evidence of "spent down" or exhausted personal economic resources and assets. Nursing home care seems very expensive. As a result, home care programmes were developed as an alternative. Home care ranges from highly sophisticated technological and specialized nursing services to personal care and housekeeping or homemaker chore services (Monk, 1994). Medicare, the largest source of public funding for home care is very restrictive and time-limited in re-imburement. In order to be covered, home care must be justified medically, usually as a restorative sequence to recent hospitalization, and for not more than 38 days of care.

Argentina has many geriatric doctors and gerontologists who provide services to needy aged. The country has long-term care private sectors. The elderly is hospitalized in geriatric units within general hospitals and sanatoriums with support from the central government. There are day geriatric hospitals where models for physical rehabilitation, psychosocial rehabilitation for neurotic patients, multi-stimulation for cerebral organs syndromes and programmes of maintenance for the physically and mentally disabled are available. Also, hospices are provided by the central government. Here, lodging, food and low-level medical assistance are given to needy elderly (Barca, 1994:7). The care-giving system of the government includes at-home medical nursing and domestic help for cleaning, preparation of food, among others. At the private level, homebound rehabilitation, nursing and accompanying therapy are offered (Barca, 1994:7).

In Malta, private involvement in health care comes from a nursing association known as Malta Memorial District Nursing Association. Initially, the association was supported by the government to become established. It now exists as an independent, non-governmental non-profit organisation which provides routine nursing care to people at their homes. About 60 percent of the beneficiaries are elderly persons (Scerri and Garrett, 1994:280).

Housing resources

Housing arrangements are important aspects of ensuring integration of the aged within their own localities after retirement. In this area, social setting available for the aged and assistance for maintaining them in the dwellings of

their choice are explained. Also, national housing policies and programmes and development of private housing industry to meet the housing needs of the aged are discussed. Community services that permit the elderly to remain in their own dwellings are also given attention.

In Germany, improvement of accommodation for aged persons is a key topic for policy development in the programmes of the federal minister for Town and Territory Planning and Housing Market. Special planning in urban and rural districts is directly influencing the living conditions of aged persons. Much attention is given to the protection of aged persons in the Social Tenancy Law where they face the risk of being displaced because of modernization or privatization of housing programme. Pensioners have enjoyed rent rebates since 1965 (Karl, 1994:131).

In Malaysia, majority (57%) of aged persons live in households of four or more people (Andrews et al, 1986:55) and the more children they have, the more likely it is that they will live with their children. If access to shelter depends on one's ties to family, then those in need of institutional shelter are likely to be single, widowed or childless (Sin and Baginda, 1994:260).

Supportive services

Supportive services help the aged develop their full capacities in personal, social and community relationships and maintain a quality of independent life. Services such as provision of information on benefits and programmes for the

elderly and meals to aged either within or outside their homes are available. Also, mental health counselling and social work services are provided.

Four major community care services are by law provided for the elderly in Japan. They include home help, day – care and respite care services and provision or rental of special appliances. Administratively, the municipal government is responsible for delivering all community care services. The cost of financing is shared by the national and municipal governments. Half of the cost of the first three services is subsidized by the national government (Shimizu and Wake, 1994:237).

Home help service helps keep family intact and enables an aged person to remain at home. Four hour service may be provided per day, six days a week giving a total 24 hours per week to elderly 65 years and above and their families in need of personal care and home making services. Services include laundering, shopping and preparation of meals and some personal care including baths. The home help services can be contracted out to other non-profit and profit making organisations that meet the national guidelines defined by the Ministry of Health and Welfare. A moderate fee may be charged if the household income exceeds a certain limit. A training programme requiring 360 hour, 90 hour and 40 hour curricula is designed in accordance with the nature of work to be performed (Shimizu and Wake, 1994:237-238).

Care programme are also provided by day-care service. Beneficiaries are residents of the community who are 65 years and above who are frail or disabled. Promotion of the aged's physical functioning is assured. The service also relieves

their sense of isolation and minimizes the burden of family caregivers (Shimizu and Wake, 1994:237-238). Legally articulated in the amended law of the welfare of the aged in 1990, the day-care centre provides;

- Core provision, including information and advice rehabilitative activities for daily living, custodial care, and education for family caregivers, health checkups, and transportation;
- Optional provision at the centre, including bathing and meal services;
- Optional home-delivery provision, including bathing, meals and laundry services and
- Sending of care workers to housing for the senior citizen (silver housing).

Sometimes, due to social matters such as illness or attendance at public occasions, family caregivers may not provide care at home. Short-term stay services established in 1978 provide respite care for the needy aged. The services are provided at accredited facilities such as nursing homes and homes for the aged. Seven days stay is the principal length of time allowed. Exceptionally, extension could be granted. Sometimes, community care promotion programme is introduced where frail or bedridden aged and their families stay together at nursing homes for a certain period to learn care giving skills. Also a night care service is provided for the severely demented aged who requires constant care during the night (Shimizu and Wake, 1994).

There is yet another programme which provides or rents special appliances for the disabled aged and their families to ease care giving and to improve their quality of life. This includes such facilities as wheel chairs, special beds and

special bath tub. Individual aged and families can utilize the programme on a sliding-scale payment basis. Apart from these defined community care services, municipal governments also provide their own supportive services with a grant from prefectural governments or with their own budget. Services range from supply of diapers and other necessary daily goods and services for the bedridden aged to subsidizing activities and transportation for senior citizens. Responsive to local needs, these services can be flexibly arranged (Shimizu and Wake, 1994).

In China, it has become a rule that the family plays a main role in taking care of the aged, along with efforts by the collective and the state. In 1982, the State Council approved the foundation of the China National Committee on Aging, whose purpose was to safeguard old people's interests, give consideration to their lives, help them play their part in life and instruct the old to work concretely. Thus a national old – age network has been formed gradually to provide opportunities for the aged (Wenmei, et al, 1994).

Leisure – time resources

The aged need to remove boredom and avoid monotony of activities such as cooking and caring for grand children and chatting with only family members. They should participate in other activities outside the home to fill their leisure-time, making such times more meaningful and adventurous. Voluntary activities may be necessary. They may also take advantage of recreational opportunities or pursue educational programmes to improve upon the use of their leisure-time.

The ultimate is to socialize, find pleasure, happiness and comfort as a way of improving their well-being.

In China, the aged make use of leisure-time depending on their social status, economic conditions, personal characteristics, aim of life, health and state and family responsibilities. Most aged live with their children and grand children after retiring from active services. They help with house work, take care of grand children and enjoy family life (Wenmei,et al, 1994:90-91).

Argentine aged is prone to spend most of their leisure time in activities limited to the home and the family with little community participation. The activities of leisure time are watching television, listening to radio, visiting and receiving visitors and shopping. Others read daily newspapers, take walks, go to the square (plaza) or attend religious services and a few attend cultural events or sports (Barca, 1994:10).

For the aged in Hong Kong, who wants to spend their leisure time outside their homes, social centres provide the most convenient places. Social and recreational activities are organised. The elderly also serve as volunteers for frail and the handicapped ones. Chatting with neighbours is commonly regarded by the aged as the most convenient way to spend leisure time (Chow, 1994).

In U. S. A. most of the recreation and socialization opportunities for the aged are found in their immediate communities, in the multi service centres, unions, civic and fraternal groups and religions organisations (Monk, 1994).

An increasing number of aged in Hong Kong are becoming followers of various religious beliefs, regarding religious activities as their major resource pursuit in life.

In Malta, formal leisure time resources for the aged are organised by both government and religious organisations. Apart from the transient and philanthropic Christmas and Easter activities arranged by a variety of clubs and organisations, the main motivator in this area is religious organisations (Scerri and Garrett, 1994).

Education is one of the important ways to enrich the lives of the aged in China. A network of multi-degree elderly education programmes has been formed and continues to be a developing trend. The aged schools are usually run by the local people while some are subsidized by the state. The aim of aged education is to broaden their knowledge and enrich their lives to achieve self – enhancement and meet personal goals (Wenmei, et al, 1994).

In Netherlands, there is increasing attention to educational resources for the aged as the number of young-old in Dutch society increases. Stimulation of senior education is a government priority. Apart from organised educational programmes, the aged are engaged in “self-directed learning”. Other traditional resources are courses in preparation for retirement; basic education for aged individuals; media education; creative, political and intellectual courses in special centres and “built-in” education in unions and advocacy groups (Schuyt, et al, 1994:301-302).

Advocacy and protection

All aged persons seem vulnerable to victimization in the society. They therefore need support against crime, maltreatment and other aged abuse. Organised efforts for advocacy and protection seem necessary. Such services may be provided by the public and the private organisations or agencies and family members among others. It is important that such groups seek to ensure a better quality of life for all aged persons and equity in opportunities for them (Kosberg, 1994).

National effort to preserve the traditional values associated with the care of the aged has been made under joint public and private auspices in South Korea. The campaign for Respect for Elders, enactment of Senior Citizens' Welfare Law and the provision of various social and health services for aged are all examples of such efforts (Sung, 1994).

In Israel, there is a Department of the Elderly in the Ministry of Labour and Social Affairs which applies governmental statute, regarding the right of protective intervention on behalf of the aged (Litwin, 1994).

Legal services for the aged have become a full-fledged professional specialty in the U. S. A. This was the consequence of the 1975 amendments to the Older American Act, which introduced free legal assistance for people over age 60. Also, professional bar associations at the state or city level provide pro-bono legal information and occasional services for low-income aged (Monk, 1994).

The major goals of South Korean Senior Citizens Association, a national institution with local agencies are to protect the rights of senior citizens to improve their living conditions and to restore their dignity and social status. An agency conducts annual seminar to promote filial piety. Several notable personalities make presentations with nationwide television transmission. Samsung and Hyundai (private companies) as well as the Ministry of Health and Social Affairs award annual filial piety prizes to those who have cared for and respected their aged parents (Sung, 1994:358).

Aging and social support in Ghana

Aging trend in Ghana

A striking feature of Ghana's population is the youthfulness of its structure. Brown (1999) observes that the proportion of persons aged less than 15 years was 44.6 per cent in 1960. By 2000 this figure was about 46.00 per cent. In contrast, the proportion of persons aged 60 and above was 4.2 per cent in 1960. By the year 2000, the proportion was about 4.5 per cent. This is collaborated by the 2000 Population and Housing Census (GSS, 2002). The population aged 60 and over in Ghana is estimated to rise by a factor of 8.5, an increase larger than 5.6 percent of the total population. Brown (1999) further notes that the low proportion of the aged in Ghana should, however, not obscure the increase in absolute numbers of this segment of the population which is increasingly becoming an important demographic variable emerging on the population scene. He also observes that the continued high rate of fertility, coupled with slowly

declining mortality rates, has resulted in a high gross reproduction rate and improved survival of its large cohorts. He then concludes that the aging of the population will get under way by 2025 when fertility rates are projected to fall quite rapidly.

According to the UN (1985), longer term projections also suggest that by 2075 fertility will have declined ultimately to bring the weight of the 60 plus age group to a situation comparable to what is to be found in many developed countries today.

The changing age structure of the population can also be shown by tracing trends in the median age. The median age of the population decreased from 17.7 years in 1960 to 16.8 years in 1980 and remained at that level (16.8 years) by the year 2000. This is due to the reduction of infant and child mortality rates. However, by 2020, the median age is estimated to be 22.1 years. This is projected to increase to 24.2 years by 2025. The rapid numerical growth in the aged population in Ghana during the period 1980 to 2025 becomes clearer if one compares the growth in the aged population to that in the population as a whole. While the total population is estimated to increase by 229.5 per cent between 1980 and 2025, the aged component is estimated to increase by 365.5 per cent during the same period. The steady increase in the number of aged persons in Ghana can be explained by the fact that the cohorts of children who will become the aged population over the next 40 years will be successively larger. This will be the result of high fertility rates of recent decades and increased life expectancy,

especially among the young. This situation also affects aged groups as well (Brown, 1999).

Social support in Ghana

As their numbers continue to increase, social support services for the aged are gradually becoming an important phenomenon for consideration. In Ghana, the informal support system constitutes the main source of social support for the aged. With the active support of friends, neighbours, an entire village community, ethnic group or clan, the family constitutes the main source of this support system. It attends to the daily needs of the aged, provides food, clothing, shelter and emotional satisfaction and encouragement. Family members also pay medical bills and rents, among others (Brown, 1992).

Brown (1992) explains that the capacity of the family to cater for the needs of the aged depends mainly on its social and economic situation, whether or not it comes under the ambit of a social security system and its actual nature or structure as a social unit. According to him, widespread poverty, limited coverage of social security and far reaching changes of the family unit structure, due to modernisation and urbanisation, have placed severe pressure on the family which continues to be the main source of social support. This has inevitably placed a burden on family care givers. Although care for the aged is the responsibility of the whole family, female members of the family constitute the major care givers. Here, the brunt of the burden is borne by wives, daughters, daughters-in-law, sisters and grandmothers. This is partly due to the fact that, traditionally, females

are considered as care givers. In the past, they remained in the home to provide care for the household, including the aged relatives (Allan, 1985; Kosberg, 1992). In some situations, some aged persons rely on only one person for major care. However, other members of the family offer some help occasionally (Jacobson, 1980).

Brown (1992) indicates that in traditional Ghanaian society, the extended family system was fully responsible for the care of the aged. So, the aged remained the responsibility of individual families, where comfort and support, in times of loneliness, helplessness and anxiety, were provided. He, however, observes that inter-dependence, which constituted the strength of the family support system, has been eroded due to increasing social change. Such a change has brought in its wake the separation of the generations through migration, death of key family members and lack of surviving siblings of elderly persons. The result is that responsibility is gradually but steadily shifting from the extended family towards the nuclear family where the spouses and children play very crucial role in the provision of social support.

However, in her contribution, Apt (1996) observes that modernization has pressurized the nuclear family to provide for themselves with little left to cater for the aged parents. She sees the future to be bleak for the aged as far as care is concerned. According to her, the aged will, in the future, receive less help and security from few children. This is because modernization, with its attendant pressure, will not make large number of children in the nuclear family desirable, resulting in few children available to care for the aged in the future. Also, the

situation may encourage the younger generation to migrate in search of greener pastures and, in the process, leave the aged behind without support.

In expressing similar sentiments, Banga (1989) observes that this situation has been reinforced by modern western education and the growth of “Youth Culture”. Accordingly, these changes have also caused profound shift in the role of the aged within the family, especially in the urban centres. So, with limited home space, income and time, the youth these days tend to withdraw from the care of the aged and concentrate on the nuclear family. Banga (1989) continues that the present generation of the aged, as a result, is more likely to have less help and security from fewer children than in the past. In effect, social change is fast weakening the fabric of the family support system as the main source of sustaining the aged. It is against this background that the formal support system is gradually becoming a very important area for serious consideration.

Quite unfortunately, however, the Government of Ghana has no specific policies to cater exclusively for the aged. Although a National Commission on the Aged was established in 1982 by the government to advise it on matters relating to the protection and care of the aged, little has been done so far. That notwithstanding, some government departments provide some support. For instance, the Department of Social Welfare and Community Development provides services for the people in the urban and rural communities respectively, which include the aged.

Furthermore, the pension scheme under Social Security Law 247 (1991) provides for workers in both public and private sectors. Under the scheme,

contributors who are sixty years and above are paid a monthly allowance which is a third of their monthly salary received just before retirement. Again, the National Health Insurance Scheme established by Act 650 of 2003 provides benefit package of diseases for all contributors. This benefit package covers 95 percent of diseases and medical support in Ghana. The remaining 5 percent of diseases and medical support not covered by the scheme include; treatment of chronic renal failure, heart and brain surgery, beautification surgery, supply of AIDS drugs, dentures, optical aids, hearing aids and orthopaedic aids. Under this scheme, the following categories of aged enjoy the package free of charge: SSNIT Pension beneficiaries who are 60 years and above, Cap 30 Pension beneficiaries who are 70 years and above and former self-employed who are also 70 years and above. As a way of recognising the contributions of the aged towards the development of Ghana, Senior Citizens Day is celebrated on 1st July of each year in Accra, the national capital to honour all aged persons.

Other supportive services complementing the traditional role of the family are voluntary organisations such as St. Vincent and Hope Society of the Catholic Church in Ghana, men's and women's Fellowships of several protestant and spiritual churches and others such as the Red Cross, Boys Scout, Help Age Ghana, Ghana National Association of Teachers (GNAT) and Women's World Banking (Ghana) Limited. In addition, there are advocacy and protection groups such as the Ghana Government Pensioners Association and the Veteran Association of Ghana, which are responsible for all civil servants and retired personnel of the Ghana Armed Forces respectively (Brown, 1992).

The conceptual framework

The conceptual framework identifies five sources of social support for the aged namely; Investments of individual aged, family support, societal support, Non-Governmental Organisations support and Government policies and actions. These five sources of social support include tangible and intangible contributions. Tangible contributions include food, shelter, clothing's, income and remittances. Intangible contributions comprise of health care, information flow, socialization, advocacy and protection, personal comfort and acceptance or rejection by family or and society such contributions determine the quality and quantity of social support which in turn influence the outcome of the support. This could be positive or negative to the well being of the aged as has been illustrated in Figure 1.

The conceptual framework found to be appropriate to inform the study is the combination of the concept of Social Support and the Input-Outcome model derived by the researcher. The conceptual framework explains the type of social support available for the aged and how and why they enjoy or do not enjoy the available social support. It would further be used to assess and evaluate the available social support system(s) for the aged. The underlying assumption of the framework is that social support for the aged is a function of the contributions of the individual aged, the family, society, non-governmental organisations and government policies and actions. The framework assumes that before the attainment of 60 years, the aged make some investments on their own. These are to sustain them in their old age. Investments of the individual aged may include own houses built, income generating activity established, such as a farm, a canoe

or a fishing boat bought or social security contributions made while in active service. Other contributions may include care for children and other members of the extended family and provision of material and moral support to communities within which the aged live.

The family could also provide such support as cash remittances, food, clothes, shelter as well as visits to provide information and comfort through socialisation. However, family support may depend on the presence, availability, ability and willingness of kins to provide for the aged.

The community also provides some support for the aged through communal contributions such as labour, material resources and visits to socialise and provide information. Societal norms expect the gainfully employed and the youth to provide for the aged. However, the contributions of the aged towards the sustainability of the society would determine the level of care that will be provided by the same society.

There is also an emerging organised support system, which supplements the efforts of the family and the local community. These are non-governmental organisations (NGOs), which provide food, clothing, medication, information as well as socialization for the aged. Government policies and actions, such as the national health insurance policy and the tax-free pension paid monthly to some former employees, also provide some relief for the aged.

Government policies and actions would also influence the community's knowledge of the needs and the problems of the aged. They would also affect the activities and the support of the NGOs for the aged. These processes would then

account for the quantity and quality of food, type of accommodation, quality and regularity of health care, information flow and transportation or movement of the aged. They would also affect the quality and frequency of socialization. Thus, the output level as a result would determine the quality and extent of social support, which constitute the overall outcome.

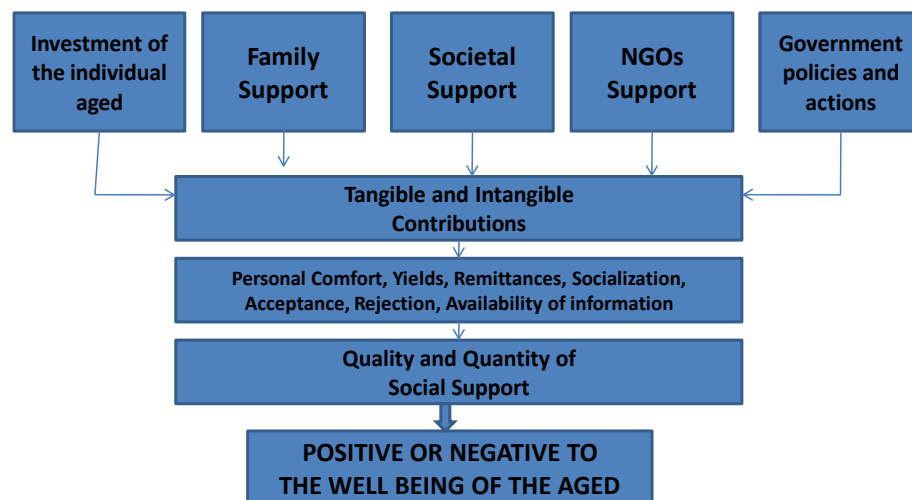


Figure 1: Social support for the aged

Source: Author's construct, (2000)

One major setback of the framework is that it assumes the aged have full knowledge of the presence and operations of all NGOs in the country. It also assumes their full knowledge of government policies and actions. However, with

the active support of such institutions as the National Commission for Civic Education (NCCE), the District Assemblies, Zonal Councils, Unit Committees, Traditional Councils and religious groups, the activities of the NGOs could be made known to the aged through public education.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter discusses the profile of the study area, the research design, study population, sampling procedures, sources of data, and research instruments used in the study. It then focuses on the data collection methods, giving details on the pre-test undertaken. Finally, it discusses the processing and analysis of the data collected.

The study area

The Cape Coast Metropolis, together with twelve (12) other districts, constitute the Central Region of Ghana. Cape Coast, the regional capital, also doubles as the metropolitan capital. The metropolis is about 145km west of Accra, the national capital of Ghana, located in the Greater Accra Region. Cape Coast is located on latitude 5 06" N and longitude 1 14" W and shares common boundaries with Komenda-Edina-Eguafo-Abrem District to the west, Twifo-Hemang-Lower Denkyira District to the north and Abura-Asebu-Kwamankese District to the east. The total land area occupies about 122.05km² with 71 localities.

The 2000 Population and Housing Census give the population of the municipality as 110,010, with the Cape Coast Township constituting about 75 percent of the total. The annual growth rate is estimated as 1.3 percent.

Cape Coast Metropolis is located in the coastal plain in the south western part of Ghana. The landscape is undulating with isolated hills. Cape Coast township is predominantly hilly. Outstanding hilly areas include the first, second, third and fourth ridges located in the south eastern part of the township. The sandy coastline is crossed by Kakum River, the main river which enters the sea near Bakan, streams and the Fosu Lagoon near Bakaano in Cape Coast.

There are several wetlands in the south western part of the metropolis which are flooded during rainy seasons from April to June from September to November. The coastal fringes are covered with coastal scrub. Mangrove is found at the mouth of the Kakum River. The middle belt is predominantly coastal savannah with few isolated trees. The northern part of the metropolis is mainly tropical rain forest vegetation.

Temperatures are relatively high throughout the year. There is high humidity which decreases from the coast inland except areas in the north which are closer to the Kakun River flowing southwards from the north east. Temperatures and rainfall increase from the coast inland with average annual temperature estimated at 26°C according to Ghana Demographic and Health Survey (2008). The southwest monsoon winds from the Gulf of Guinea in the south are predominant throughout the year. The Harmattan, a dry desert wind is felt mainly in January.

There are 18,000 farmers (Ministry of Food and Agriculture, 2008) and 5,173 fisherfolks (MOFA 2006) actively engaged in the Metropolis. Other workers include traders, artisans, civil and public servants. Cape Coast is the main centre of business activities. Traders from many parts of the Metropolis, Mankessim in the Mfantseman West District of the Central Region, Sekondi-Takoradi in the Western region and Accra converge at Kotokuraba market, the main market centre each Sunday for brisk business in second hand goods.

The metropolis has a large water treatment plant at the headwaters of the Kakum river located at Brimsu. This is under the management of Ghana Water Company which supplies portable water to all parts of the Metropolis. It has a large electricity sub-station supplying electricity for domestic, commercial and industrial purposes.

The metropolis is a very important tourist destination. It can boast of the famous Cape Coast Castle, Fetu Afehye Festival, the Kotokuraba Sunday market, Brimsu Water Works, many of the oldest but popular Senior High Schools in Ghana, 3 training Colleges, a University, the oldest Churches in Ghana and many hostels and restaurants. There is also a crocodile pond at Hans Cottage Hotel near Mpeasem. It also provides the main route through Brabedzi in the north to the famous Kakum National Park; a few kilometres away in the Twifo-Hemang-Lower-Denkyira District of the Central Region.

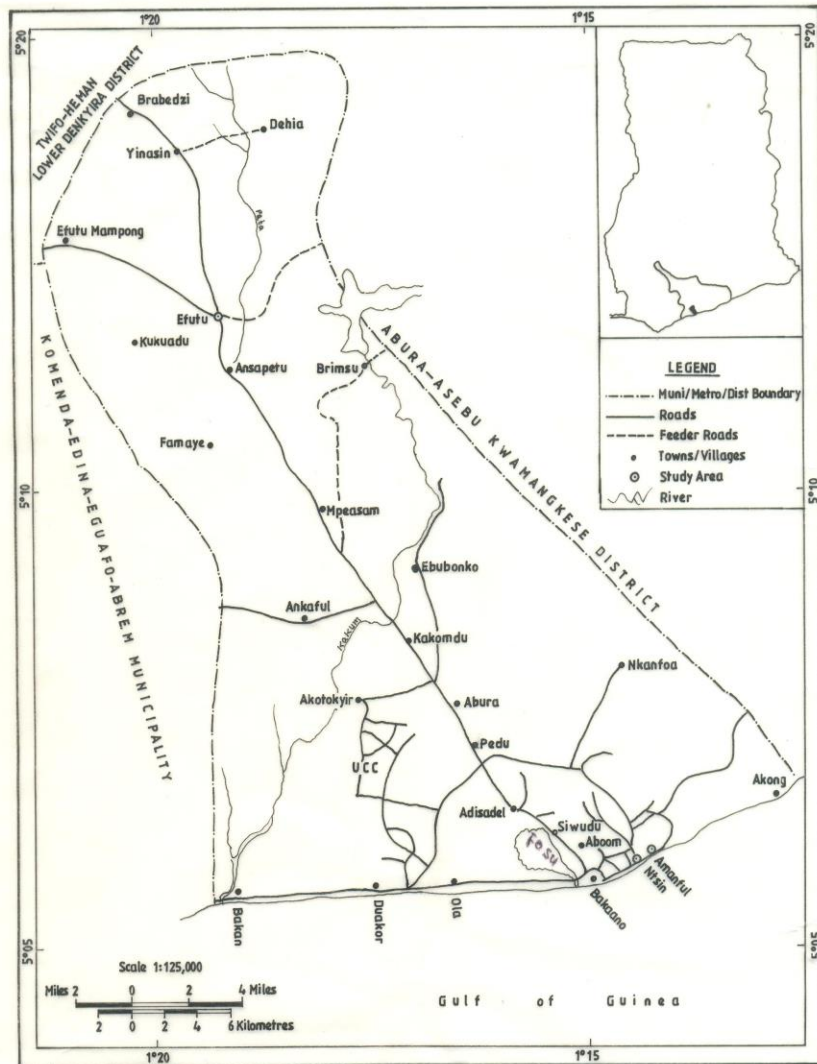


Figure 2: Cape Coast Metropolitan Map showing the study areas

Source: Department of Geography and Regional Planning, UCC (2003)

Research design

In social scientific study, research design refers to the logical sequence that connects the empirical data to a study's initial research questions and ultimately its conclusion (Yin, 2003).

Nachmias and Nachimias (1996) describe research design as a plan that guide the investigator in the process of collecting, analysing and interpreting observations. The use of multiple sources and methods conceptually referred to as triangulation was employed to enhance and facilitate fieldwork on the phenomena under study. Combination of both qualitative and quantitative methods is very important when looking at an issue. This is varied against the fact that it is better to study an issue from several angles for better understanding than looking at it from only one.

However, the problems associated with the use of triangulation cannot be overlooked. Some authors argue that apart from the theoretical justification of triangulation and the positivist impression it seems to entail, there is no evidence to suggest that studies based on triangulation necessarily produce more valid results (Sarantakos, 1998).

As a result, the integration of multiple data sources, theories and methods in the present study will better enable the researcher to forge valid propositions that consider casual factors. The study therefore, has both positive and interpretive aspects. Some aspects of data needed for instance the social support available to the respondents and the providers of such support will be better understood from a positivist perspective and thus, the use of quantitative data will

allow further analysis such as cross tabulation to be performed, helping to demonstrate patterns. The qualitative standpoint provides deeper insight into how the respondents perceive social support and how the support could be improved to enhance their well being.

The study population

The study population included aged persons aged 60 and above. They were selected from both urban and peri-urban areas of Cape Coast Metropolis of the Central Region as shown in Figure 2. In the urban area, Ntsin and Amanful Communities of Amanful-Ntsin Zone were randomly selected while Efutu Community representing the Peri-urban area was also selected randomly from Efutu-Kokoado-Mpeasem Zone to interview the respondents.

In all, 140 respondents were interviewed. They included 105 respondents from the urban area and 35 respondents from the Peri-urban area respectively. The proportional allocation made took into consideration the proportion of elderly in the urban and Peri-urban areas of the study area. In the urban area, the 105 respondents included 54 females and 51 males respectively. The 35 respondents from the Peri-urban area also included 20 females and 15 males respectively.

Sources of data

Primary and secondary sources were used to obtain data for the study. The primary data comprised interviews, focus group discussion and field observations. This was supplemented with secondary data from the Cape Coast branch of the

Ghana Pensioners Association, Metropolitan Headquarters of Religious Bodies (Catholic Secretariat; Christian Council; Pentecostal Council; Islamic Council), the Central Regional Headquarters of the Ministry of Women and Children's Affairs, and Metropolitan Headquarters of the Non-Formal Education Division (NFED) of the Ministry of Education. Published and unpublished literature on theoretical insight into the subject matter was also used.

Sampling procedures

The Cape Coast Metropolitan Assembly comprise five (5) Zonal Councils. These include: Efutu-Kukuadu-Mpeasem; OLA-University-Duakor; Abura/Pedu; Aboom-Bakano; and Amanful – Ntsin Zonal Councils. Based on the Ghana Statistical Service demarcation, the study area was stratified into urban and peri-urban areas. The whole of Efutu-Kokoado-Mpeasem zone and fourteen (14) localities of the other four (4) zones, as listed in Table 1, with a population of 27,719, represented the Peri-urban area while the first three localities (Cape Coast (Central), Cape Coast (Pedu/Abura) and Cape Coast (University/OLA) represented the urban area, with a population of 82,291.

Cape Coast (Central) consists of Aboom - Bakano and Amanful-Ntsin Zonal Councils: Cape Coast (Pedu/Abura) also consists Abura/Pedu Zonal Council while Cape Coast (University/OLA) includes OLA - University-Duakor Zonal Council respectively. The names of the localities and their respective population are indicated in Table 1.

Table 1: Localities and their population in the Cape Coast Metropolis [n = 140]

Locality	Population
1. Cape Coast (Central)	57,027
2. Cape Coast (Pedu/Abura)	15,326
3. Cape Coast (University/Ola)	9,938
4. Ekon	3,443
5. Nkanfoa	2,995
6. Kakomdo	2,2628
7. Efutu	2,214
8. Akotokyir	1,605
9. Antoesuekyire	1,557
10. Ankaful Village	1,592
11. Apewosika	1,547
12. Koaprow	1,473
13. Esuekyir	1,453
14. Kukuadu	1,386
15. Amamoma	1,068
16. Nyinasin	1,053
17. Duakor	1,039
18. Koforidua	950
19. Amissano	848
20. Mpeasem	868
Total	110,010

Source: Ghana Statistical Service (2002)

Given the population of the study area as 110,010 and given that the aged (60 years and above) constitute 5.8 percent of the total population (GSS, 2002), a sampling frame of 6,381 was used to arrive at a reasonable number of respondents to be interviewed. About 5 percent of the target population estimated at 319 was

initially considered. However, due to time-limit and financial constraints, 140 respondents, constituting 48 percent of the target population were finally interviewed.

Based on the urban and peri-urban distribution of the total population of the Cape Coast Metropolis, 105 respondents were drawn from the urban area while 35 respondents were also drawn from the peri-urban area respectively. A multi-stage sampling procedure was used for the selection of respondents.

The first stage involved the zoning of the metropolis into five clusters in line with Cape Coast Metropolitan Assembly's zonal council demarcations.

At the second stage, two zonal councils namely Amanful – Ntsin and Efutu–Kukuadu- Mpeasam zonal councils were randomly selected to represent the urban and peri-urban areas of the study respectively.

At the third stage, Ntsin and Efutu communities were randomly selected from Amanful-Ntsin and Efutu-Kukuadu-Mpeasem zonal councils respectively to generate the number of respondents to be interviewed. Ntsin community alone could not account for the total number of respondents in the urban. As a result, Amanful community was purposively selected to account for the remaining number of respondents in this area.

The final stage involved the selection and interviewing of respondents using purposive and snow ball sampling techniques. The latter was employed with the assistance of Assembly members and opinion leaders in the selected communities. Where there were two or more aged persons in a house, the oldest person was chosen for the interview. The respondent in turn identified other aged

persons within the community to be interviewed. The distribution of respondents in the study area is indicated in Table 2 below.

At the zonal level, Ntsin community was randomly selected for the purpose. On the one hand the community could not account for the total number of respondents expected, so Amanful community was purposively selected to make up for the total number of respondents needed in the urban area. On the other hand, Efutu community of Efutu-Kukuadu-Mpeasem zone was randomly selected from the seventeen peri-urban communities (as indicated in Table1) to represent the peri-urban area. The total number of respondents were obtained using snowball sampling technique. This involved identification of a respondent with the assistance of an assemblymember or an opinion leader.

Table 2: Distribution of respondents in the study area [n = 140]

Zone	Community	Male Percentage	Female Percentage	Total respondents
Urban:				
Amanful-Ntsin	Ntsin	44.0	48.7	46.4
	Amanful	33.3	24.3	28.6
Peri-urban:				
Efutu-Kukuadu				
Mpeasem	Efutu	22.7	27.0	25.0
Total		100.0	100.0	100.0

Source: Field survey, 2003

After collecting the needed information, he or she was subsequently asked by the researcher to identify others within the area of research for the same purpose. The process was continued until the total number of respondents were obtained. Table 2 indicates the distribution of respondents in the study area.

Research instruments

Three data collection instruments were employed to solicit information for the study. These were the interview schedule, observation and focus group discussion.

The interview schedule involved one-on-one interview using a structured questionnaire. The researcher, with the support of field assistants conducted a face-to-face interview with all respondents in which the subject matter of the study was explored in detail. For the purpose of this research, the schedule was structured into five sections, namely; socio-demographic characteristics, socio-economic characteristics, availability of social support, activities of daily living and perception of social support by the respondents.

While conducting the interview, the researcher and the field assistants used the occasion to look round the physical environment of the respondents to make some observations regarding how tidy the environment was, how healthy and strong the respondents looked and how neatly they were dressed.

The researcher organized one brain storming session for members of Central Regional branch of Ghana Pensioners Association at their own premises. This

included 9 females and 27 males giving a total of 36 members. The discussion lasted 1 hour 45 minutes.

Playing the role of a moderator, the researcher ensured that all members had equal opportunities to make contributions towards the discussion (See Appendix 2 for a copy of the Brain Storming Session Guide).

Data collection

Pretesting of instruments

The pre-test began from 2nd July 2003 and ended on 5th July 2003, giving 3-day duration. The researcher administered an average of 4 interview schedules daily. The exercise started at 9.00am each day and ended at 4pm. The main difficulties encountered and modifications made after the pre-test included the following;

- Some question seemed irrelevant for the purpose of the study, while others were similar. They were therefore removed;
- Some questions were either too long or ambiguous and had to be reframed;
- Some respondents were reluctant to co-operate, complaining that other researchers had visited them for other interviews but had never benefited from them. The researcher had to assure them that the exercise was purely for academic purpose and that government intervention could be possible but not immediate;

- Few respondents were so ill and/or weak to avail themselves for the exercise, thus making it difficult to cover as many respondents as possible within a day. Others complained of hunger and that they will take some money for food before they availed themselves for the exercise. The researcher had to part with some amount of money to have the work done. Some will intermittently call for a break to either receive visitors or prepare their meals;
- In some situations, the researcher had to visit a household twice or more before administering the interview schedule. Respondents were busy Doing one thing or another else or were not available at home; and
- Some narrated experiences in life, which were not relevant to the exercise. The researcher had to exercise patience and restraint to avoid embarrassments, thus using too much time to administer an interview schedule.

Actual fieldwork

The researcher organized a one-day training programme for six (6) people from the study area, out whom four (4) were selected as field assistants. They assisted the researcher to administer 140 interview schedules on randomly selected respondents during the actual fieldwork. The actual data collection was preceded with a pretest to gain first-hand knowledge of the exercise and to examine any possible difficulties likely to be encountered when administering the interview schedule finally.

The actual fieldwork started in late 25th August, 2003 and ended on 28th September, 2003, giving five (5) week duration. The researcher and each field assistant administered an average of 28 interview schedules. Much of the field work started at 9.00am and ended at 6.00pm each day. Saturdays and Sundays were the most suitable days for the exercise as most interviewers were fulltime employees who could not utilize the weekdays effectively.

Data processing and analysis

The data processing began with the editing of the 140 interview schedules for consistency and orderly presentation of information from the field of study. Subsequently, coding was done to enable the researcher take note of the frequencies of the various variables for analysis.

The Statistical Product for Service Solution (SPSS) programme was used to process and analyse the data. The analysis involved cross-tabulation of both dependent and independent variables. This was to find associations and relationships, where necessary, to help draw relevant conclusions based on the hypotheses and the objectives of the study. Some of the variables were also subjected to statistical test such as Chi-Square and 'T' tests, all with a view to making well informed analysis for acceptable and relevant conclusions to be drawn.

Limitation to data collection

The main difficulties encountered in the fieldwork were similar to those encountered during the pre-test. However, three others encountered were:

- Some field assistants were slow at administering the interview schedule. Further pieces of advice were given them to be more business – like and not to encourage respondents to narrate their past experiences irrelevant to the study to take much of their time on the field; and
- So much time was still taken to administer each interview schedule even after the initial corrections were effected. This was because questions were involving but very necessary for the purpose of the study. Considering the time limit for the completion of the thesis, the original number of interview schedules had to be reduced from 200 to 40 in order to work within time.
- Some of the field assistants were gainfully employed so they used the week-ends and evenings of the week days to administer the interview schedule, hence the long delay.

In general, the programme was successful as respondents opened up for very healthy interactions after the initial difficulties. Some were satisfied that they had had the opportunity to discuss their problems and shared their views with people who could send their grievances to government for redress. They however, acknowledged the fact that there could be delays in addressing their problems.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This initial chapter of the analysis explores the background of the respondents. It covers their social, demographic and economic characteristics, the type of social support system(s) available for the aged, those involved in the provision of the support and performance of activities of daily living.

This chapter begins with discussions of respondents' perceptions and reactions to available social support at home and the community and how they rate this support. It further discusses how various formal support systems in selected countries of the world have improved the welfare of the aged in those countries. The chapter concludes that with the introduction of an explicit policy of formal social support system for the aged in Ghana, their well-being could be improved and sustained.

Socio-demographic and economic characteristics

Age–sex distribution

In terms of sex distribution of the elderly, 74 (52.9%) were females and 66 (47.1%) were males. The mean age of the respondents was 71.8 and the age-sex distribution of the sample is provided in Figure 3.

Percentage

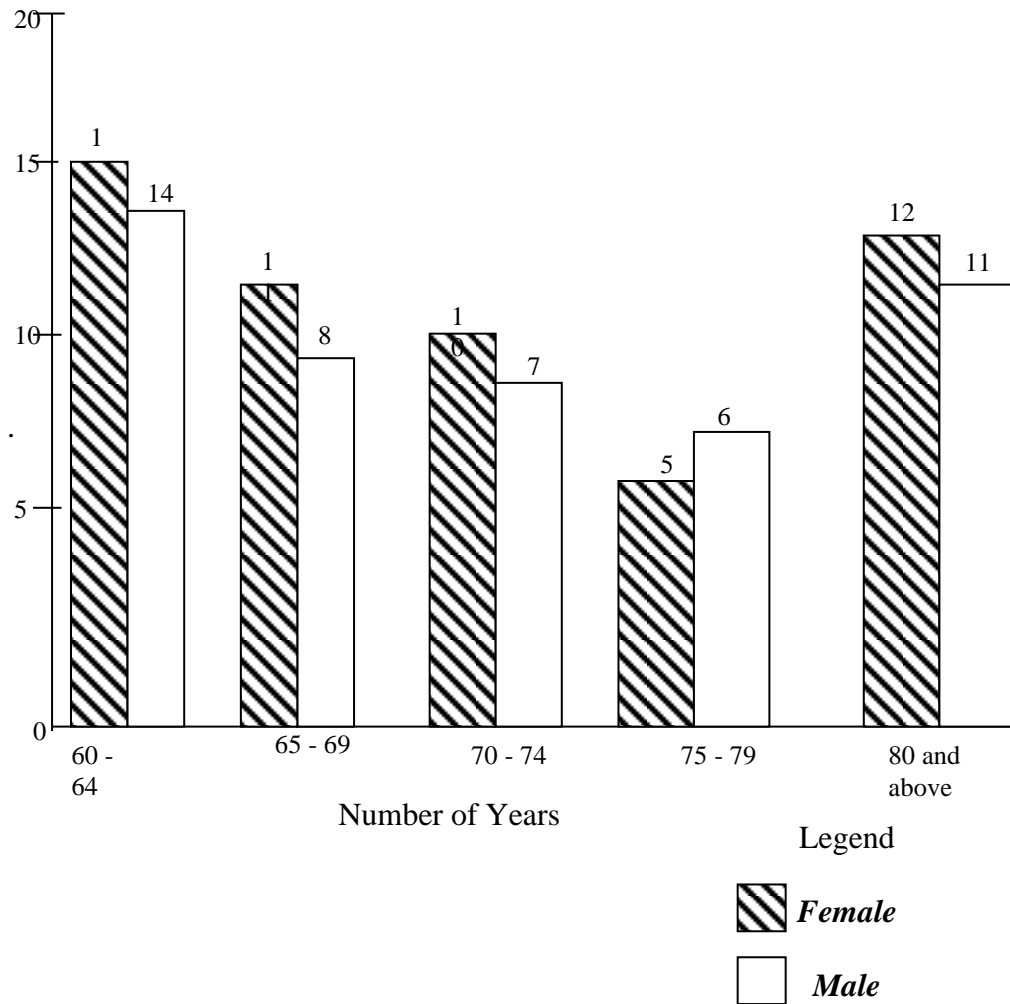


Figure 3: Age-sex distribution of the aged

Source: Field survey, 2003

Marital status

The marital status of respondents indicated that 45 percent of those interviewed were married and continued to live with their spouses. However, 35 percent were widowed, 10.7 percent divorced, 7.9 percent separated and 1.4 percent single.

Majority of respondents (55 %) therefore, had no spouse to keep them company. Having lost their life partner, the aged needed companionship from the family to make up the relationship vacuum created. Sometimes it may be expedient for the children to suggest or assist their widowed parent to look for a prospective partner and forge a relationship which could eventually result in a marriage. For the same reason, divorce or separation sometimes does not seem healthy for the parties involved as one may eventually grow into old age. Indeed, emotional and psychological satisfaction through socialization among couples is a necessary part of social support, especially among the aged. This is because the aged might have lost workmates, classmates and close relatives and friends. This is viewed against the fact that children who are now the main core providers for the aged could not provide enough companionship due to their responsibility to their nuclear family. It was heartening, however, to observe that some respondents (45 %) continued to live with their spouses. As a result, a level of socialization could be maintained and improved upon to better their well-being.

Number of children

Altogether, the respondents had a total of 719 children. This included 370 sons and 349 daughters respectively. One of the respondents had as many as 16 sons, while two others had 10 and 7 sons respectively. Also, 25 respondents had only a son each while another 25 respondents had two sons each who were still alive. For those who had daughters, one of them had as many as 13 daughters. This was followed closely by another who had 11 daughters. Also, 18

respondents had a daughter each while as many as 82 respondents also had 2 daughters each who were still alive.

The mean number of sons and daughters were 3.03 and 3.01 respectively with the mean number of children for each respondent given as 5.45. Also, the mean number of sons (3.03) had a standard deviation of 1.93 with approximately 2/3 of sons falling between 1.10 – 4.96. Again, the mean number of daughters (3.01) had a standard deviation of 1.90 with approximately 2/3 of daughters falling between 1.11 – 4.91. This gave the standard deviation of mean number of children (5.45) as 2.93, with approximately 2/3 of children falling between 2.52 – 8.38.

Table 3: Number of children [n = 140]

Number of children	Male percentage	Female percentage	Total percentage
1	6.8	5.1	6.0
2	13.5	23.4	18.3
3	24.3	17.1	21.0
4	28.1	21.7	25.0
5	13.5	11.4	12.4
6	4.9	8.5	6.6
7	1.9	6.0	3.8
10	2.7	0	1.4
11	0	3.1	1.5
13	0	3.7	2.2
16	4.3	0	2.2
Total	100.0	100.0	100.0

Source: Field survey, 2003

Out of the 370 sons, 91.9 percent were looked after by their parents. On the average, therefore, each respondent looked after 2.8 sons. Again, out of the total number of 349 daughters, 58.7 percent were looked after by their parents. The average number of daughters cared for was 1.8. As a result, the average number of children whom respondents cared for was 4.1, representing 75.8 percent of the total number of children.

The total numbers of respondents' children working were 372 (51.7 %). This included 205 sons (55.4 %) and 167 daughters (47.8 %). On the average, about three children of each aged person were working whilst the other two were not. They were either in school, learning a trade or could not find a job. Over 70 percent (255) of the total number of daughters were married with children. Also 63.2 percent (234) of total number of sons were married with children. This means that 68.0 percent (489) of the total number of children were married with children. This placed the total number of children who were responsible for nuclear family at about four.

Given a mean of 5.45 children, including 3.03 sons and 3.01 daughters, still alive, the aged, therefore, had quite a good number of children who could possibly cater for their welfare. However, this depended on whether or not the aged looked after their children, the children were gainfully employed or the children were responsible for their own nuclear family. Almost all the respondents (97.9 %) had looked after most of their children (91.3 %). Each of them managed to look after 4.7 out of an average of 5.45 children. They provided for their children's basic needs, such as food, clothing and shelter. They paid their school

fees, provided other educational materials and offered some pieces of advice. Very few respondents (2.1 %) could not care for their children (8.7 %) because they were financially less endowed to cater for all of them. Some family members, friends or philanthropists might have taken up the responsibility of caring for these few children. Again, three (3) children of each respondent were in employment whilst the other two remained unemployed. The possible reasons which could be assigned to this development were that job opportunities were probably not adequate to absorb them; some were still in school or learning a trade. This situation could have placed a burden on the three employed children who provided the needs of their aged parents as well as their nuclear family. This is viewed against the fact that four of the children of each aged were also responsible for their own spouses and children. This implied that one child who was responsible to a nuclear family was unemployed. It will have been difficult for such a child to provide financial and material support for the aged parents, whilst desperately trying to cater for the nuclear family under the circumstance. It was based upon similar observation that Apt (1996) sees the future to be bleak for the aged. According to her, the aged will, in the future, receive less help and security from few children. Banga (1993) also observed that this situation has been reinforced by modern western education and the growth of 'Youth Culture'. Accordingly, the youth with limited income and time tend to withdraw from the care of the elderly and concentrate on the nuclear family. It is against this background that the author argues that the formal support system is gradually becoming a very important area for serious consideration.

Educational attainment

With regards to educational attainment, over half (54.3 %) of respondents had no formal education. However, 20.9 percent had completed middle school, 5.7 percent had primary education, while 4.3 percent attended technical school. Also, 3.6 percent had vocational training, while 2.1 percent attended teacher training, polytechnic, secondary (G.C.E. O’Level) and university or its equivalent respectively. Only 1.4 percent had non-formal education and G.C.E. ‘A’ Level respectively.

Table 4: Educational attainment [n = 140]

Educational Attainment	Percentage
Primary school	5.7
Middle School	20.9
G.C.E ‘O’ Level	2.1
G.C.E ‘A’ Level	1.4
Vocational Training	3.6
Technical Training	4.3
Teacher Training	2.1
Polytechnic	2.1
Non-Formal Education	1.4
University/equivalent	2.1
No Formal Education	54.3
Total	100.0

Source: Field survey, 2003

Most of the aged interviewed during the study happened to grow up before the opportunity for formal education became available. There were however,

some who took advantage of the limited number of educational centres with long Christian Missionary contact in southern Ghana (Brown, 1992). As a result, a large number of them (54.3 %) in the Cape Coast Metropolis did not receive formal education. Some (45.7 %), however, managed to receive formal education at one level or the other. More than half (26.4 %) of such aged did not go beyond basic education. Their parents seemed to have had barely enough to provide for the basic needs of the family as subsistence fishing and farming were their main occupations. The acquisition of basic education seemed enough for a child to learn a trade such as carpentry, masonry, tailoring and painting. Some 10.0 percent could go further to receive vocational, technical and teacher training. A few of them (3.5 %) also obtained secondary education. It was not surprising then that an insignificant proportion (2.1%) made it to the polytechnic and university levels respectively. A few others (1.4 %) also decided to acquire non-formal education as a way of improving their human resource capacity for better living.

One major factor that seemed to have eroded the traditional roles and authority of the aged as custodians of wisdom and knowledge is formal education. This has introduced new values, an enquiring mind and projections of new models of social relations (Brown, 1992). Inevitably, the situation has come into conflict with the traditional roles and authority of the aged. Accordingly, the young in the society now seek advice from teachers and other contemporary social leaders instead of the aged. Again, with their high educational background, they have become independent and sometimes ignore or challenge the authority of the aged (Brown, 1992).

Occupational status

Before the age of 60, majority (37.2 %) of the respondents were fisherfolks. Others (21.4 %) were professionals, sales workers (15.7 %) and farmers (9.3%). However, a few (5.7 %) were administrative workers and in other trades respectively. There were a few also (5.0 %) who were clerical workers.

Table 5: Occupational status before age 60 [n = 140]

Occupational status	Percentage
Professional	21.4
Administration	5.7
Clerical Staff	5.0
Sales/Service worker	15.7
Farming	9.3
Fishing	37.2
Other	5.7
Total	100.0

Source: Field survey, 2003

At retiring age, some of the respondents (46.4 percent) continued to work to make ends meet. The remaining 53.6 percent assigned various reasons for not working any longer: Over 70 percent of these respondents indicated that they were too old to work, 14.8 percent said they did not have capital to work with, but 8.0 percent felt they could not work owing to ill-health, while about 5.2 percent did not respond at all.

Half of the aged (50.0 %) interviewed were engaged in subsistence fishing and farming and related work, with fishing (37.2 %) constituting the main occupation in the Metropolis. The economic activities engaged by the aged seemed to correlate with their educational attainment, since as many as 54.3 percent had no formal education. There were, however, some professional and related workers (21.4 %) who were engaged in small-scale industry such as carpentry, masonry, tailoring and painting, with others (15.7 %) in small-scale trading. Only 10.7 percent were engaged in white collar jobs as administrators, clerical officers and related workers. There were others (3.6 %) in self-employment and dealing in blacksmithing, letter writing, and pottery, sand winning and quarrying. The discovery that most of them (90.7 %) were engaged in subsistence form of economic activity indicated that most of the aged in the Metropolis could be low income earners. Consequently, they could neither save nor invest enough to enjoy adequate social support at old age. It was not surprising therefore, to observe that many (46.4 %) continued to work at a time when they had to retire from active work.

Over 50 percent of the aged (53.6 %) were not engaged in any economic activity. This category assigned various reasons for their current status. Among them were very few (7.9 %) who wanted to continue working but could not do so owing to lack of capital. This finding supports the assertion that saving was a difficult undertaking, considering the subsistence nature of their economic activities. Again, it negates the views of Cumming and Henry (1961) that there is natural and inevitable mutual withdrawal as one is aged. Among the aged, one

reasons assigned for not engaging in any economic activity was lack of capital. Their withdrawal therefore was neither natural nor inevitable as equally observed by Atchley (1987) who further asserts that most cases of disengagement result from lack of opportunities for continued involvement. Where financial support in the form of loans are made available to the aged who needed capital to continued working there will be no case of disengagement.

Aside from this category were a few others (4.3 percent) who had wanted to work but for their ill-health. In activity theory, a person must have the physical and mental capacity to perform an activity. However, retired people cannot easily find jobs, sometimes, because of continuous decline of their physical and mental capacity. Thus, although substitution may be a feasible and attractive way to cope with loss early in life, it becomes difficult to put it into practice (Cavan et al, 1949). Again, Clark and Anderson (1967) also observed that ultimately, the balance among consolidation, substitution and disengagement depends very much on health. Good health, according to them, is a pre-requisite for the consolidation and substitution approaches to coping with role and activity losses. Furthermore, the aged who are in poor health are much more likely to be forced into disengagement. Whilst many (90.2%) of farmers continued to work using simple tools as cutlasses, hoes and sticks none of the fishermen continued fishing since it is a strenuous activity which demands much strength and energy as compared to farming. In activity theory, the aged could continue to work when an alternative is available and that they are willing and able to work. Many (87.4%) of them therefore resorted to mending fishing nets, repairing canoes and boats as well as

sand and stone winning for construction purpose which were the alternatives available.

The desire expressed by as many as 58.6 percent for continuous engagement in economic activity at retiring age also revealed that the available social support was not adequate enough. This is also a pointer that the extended family support for the aged has reduced drastically. As Apt (1996) indicated, formal education, urbanization and the introduction of western cultural values have made the nuclear family more important and preferable. Moreover, the aged themselves also recognised that their children, who were the main care-givers, could not provide all their needs, hence the need to rely on themselves for their own support and a call for formal support. This call confirms Banga's (1989) assertion that the formal support system is gradually becoming a very important area for serious consideration.

Provision of social support for the aged

Social support received by respondents included cash remittance, feeding, clothing, information flow, accommodation, medication and visits when sick. The main providers were their daughters, sons, spouses, relatives, friends and institutions/organisations. However, respondents themselves also provided part of the support for their own up keep. The informal social support system was the main means of support available to them.

Cash remittances

Generally speaking, both daughters and sons were the major source of cash remittances to aged in the proportion of 22.2 percent and 21.7 percent respectively. Interestingly, 17.2 percent of the aged themselves provided their own financial support from their pensions and investments; whilst 3.9 percent received such support from relatives. Additionally, 2.8 percent relied on spouses, 2.2 percent received support from friends, with 1.1 percent receiving their remittances from institutions/organisations and other sources respectively. Sadly though, 27.8 percent of respondents did not receive any cash remittances from any source.

Feeding

Many of the respondents (42.5 %) provided their own means of feeding; 18.4 percent were fed by their daughters; 15.1 percent by spouses and 13.4 percent by their sons. Relatives accounted for 7.2 percent, while 3.4 percent relied on friends for feeding. Institutions/organisations and others did not play any role in respect of feeding.

Clothing

A large number of respondents (43.8 percent) provided their own clothing; 25.9 percent were clothed by their sons; 20.4 percent by their daughters; 5.4 percent by relatives; 2.0 percent by spouses; 1.5 percent by friends and 1.0 percent by others.

Accommodation

Quite a number of respondents (47.9 %) provided their own accommodation. However, 36.4 percent lived in family houses, whilst 9.2 percent were accommodated by others. A few (5.1 %) were also accommodated by spouses and friends (1.4 %). Sons, daughters and institutions/organisations did not provide any accommodation facilities directly for respondents. Many respondents (46.5 %) maintained their accommodation. The relatives of over a fifth (22.2 %) of respondents were responsible for the maintenance. Some (10.8 %) had their accommodation maintained by sons, daughters (9.2 %), spouses (8.6 %), others (1.6 %) and friends (1.4 %).

Information flow

Generally, the aged received information on good health practices, where to find job and where to find leisure away from home. Some respondents (26.7 percent) received information regularly from relatives; 22.7 percent from daughters; 17.5 percent from friends; and 15.9 percent from sons. Also, 9.6 percent received information from spouses; 5.6 percent from others, while 2.0 percent relied on institutions/organisations.

Medication

Many respondents (47.4 percent) were directly responsible for their own medication. However, some (24.2 percent) also relied on sons, daughters (19.4 percent), spouses (3.4 percent) and relatives (3.4 percent) respectively. The

remaining few also relied on friends (1.1) and institutions/organisations (1.1) respectively for medication.

Visits when sick

On wellness and good health, it was discovered that when sick, 25.7 percent of respondents received visits from their daughters, 23.2 percent from their sons and 24.8 percent from other relatives. Some (12.7 %) were visited by their spouses and friends (11.1%). Institutions/organisations visited a few of them (1.2 %) while a few were also (1.3 %) visited by others.

Provision of social support

In the provision of social support generally, some of the respondents (28.4 percent) were on their own. However, 18.4 percent were supported by daughters and 17.7 percent by sons. In effect, a relatively large number (36.1 percent) were supported by their children. Also, 20.4 percent relied on relatives, 8.5 percent on friends, 4.5 percent on others and 2.1 percent on institutions/organisations for their total support.

Considering regular visits of the family to the respondents within the past six months, 64 percent of them had received visits from daughters and 61 percent from sons, giving an average of 63 percent of respondents who received regular visits from children. This was viewed against 58 percent of respondents who received such visits from relatives within the stipulated period of time.

Furthermore, 49 percent of respondents were visited by their daughters daily or every other day, whilst 37 percent were also visited by their sons daily or every other day. On the average therefore, 43 percent of respondents received visits from their children daily or every other day. This was also viewed against 38 percent who received visits from their relatives daily or every other day.

The informal support system seems to be the main support system available to the aged in the study area and perhaps many areas in Ghana. The formal support system is yet to make any impact. Social support provided by the informal support system included cash remittances, feeding, clothing, information flow, accommodation, medication and visits when the aged were sick. The major responsibility of care lay on children (36.1 %), with daughters making the largest contribution of 18.4 percent. Indeed, the aged themselves were major providers of their own support (28.4 %) coming second after the children. This may be viewed against the relatively low support provided by relatives (15.4 %). In their contribution towards the care of the aged, children provided more than twice what relatives or the extended family could provide.

The aged themselves provided nearly twice what the extended family could provide. The onus of responsibility of care had, understandably, shifted from the extended family to the nuclear family where children are now the main care-providers as observed by Brown (1992). The fact that children show greater concern for the welfare of the aged than other providers is also confirmed by the results of the three hypotheses. Hypothesis one states that the aged whose medical bills are paid by their children are more likely to be dissatisfied with their

payment arrangements than the aged whose medical bills are paid by others. This hypothesis is based on the premise that children do not play any significant role in the payment of medical bills of their aged parents. The rationale behind this hypothesis is that medication constitutes a major support of the aged owing to their deteriorating health. Therefore it sought to find out whether or not children are really the care givers who show greater concern for the health needs of their aged parents. The results indicate that there is a significant difference in the payment of medical bills between the aged with children and the aged without children.

Again, hypothesis two states that the aged who continue to live with children are more likely to be dissatisfied with the quality of their accommodation than the aged who are living with others. The result showed that the aged who continued to live with children are more satisfied with the quality of their accommodation than the aged who are living with others. The results revealed that 73 aged with children had their medical bills paid by their children while 16 aged without children had had to pay their own bills or rely on others.

Similarly, hypothesis three states that the aged who continue to receive support for meals from children are more likely to be dissatisfied with their meals arrangements than the aged who do not receive support from their children. It was revealed that the aged who continue to receive support from their children for meals are more satisfied with this arrangement than the aged who receive such support from others. The two results, therefore, re-enforce the assertion that children are the main providers of the care for their aged parents.

It is worthy to mention that spouses (7.3 %), friends (5.5%), others (2.5%) and institutions and organisations (0.8%) also expressed concern for the care of the aged in the metropolis, the study area, however meagre their contributions. This tends to support Kosberg's, (1994) argument that, the provision of social support for the aged continues to be a shared responsibility among families, friends, neighbours and members of a collectivity.

In any case, the study also revealed an emerging phenomenon where the aged themselves seem to be making efforts at providing for their own upkeep. This has come about because Apt (1996) has observed, modernization seems to pressurize the nuclear family to provide for them with little left to cater for their aged parents. Banga (1989), buttresses this point when she also posits that with limited home space, income and time, the youth these days tend to withdraw from the care of the aged and concentrate on the nuclear family. Brown (1992), explains further that the capacity of the family to cater for the needs of the aged depends mainly on its socio-economic situations, whether or not it comes under the ambit of a social security system and its actual nature or structure as a social unit. According to him, widespread poverty, limited coverage of social security and far reaching changes of the family unit structure, due to modernization and urbanization, have placed severe pressure on the family which continues to be the main source of social support. This has inevitably placed a burden on family caregivers.

In effect, social change is fast weakening the fabric of the family support system as the main source of sustenance for the aged (Banga, 1989). The

implication is that, the future seems bleak for the aged as care is concerned which implies that, the aged will in the future receive less help and security from few children (Apt, 1996). It is against this background that one observes in the study, the efforts made by the aged themselves at providing their own support as quite understandable. This seems to be a response to the realisation that they could no longer rely entirely on family support for their upkeep. This situation then raises concerns regarding independent living of the aged without family support; especially where the study revealed that a large number of aged (53.6 %) were not engaged in any economic activity. Among the reasons given were that, jobs were not readily available, there was no start-up capital to begin own businesses or their ill-health could not allow them to work. Even where job opportunities were available as in Canada, for instance where late-life employment is likely to be in part-time basis, these were often lower-paying service jobs (Kosberg, 1994). The fact also remains that retired people cannot easily find new jobs because of continuous decline of their physical and mental capacities as indicated by a few (5.3 %) respondents in the study. As they continue to age, therefore, the aged may find it difficult to lead life independent of social support; be it informal as may come from the family, friends or the community or formal as may be provided by the government or the private sector.

The study, however, observed that, a very large number of the aged (92.9%) seemed contented with the quality of social support provided. They recognised the support as excellent (5.7%), very good (27.9%), good (34.3%) or satisfactory (25.0%). Less than 10 percent described it as poor. Again, children

seemed to play a leading role in providing good quality support as exemplified by the results of hypothesis two where many of the aged (90.0%) who lived with their children expressed satisfaction with the quality of accommodation compared to relatively lesser number of aged (52.5%) who expressed satisfaction with the quality of accommodation provided by others.

Activities of daily living

One of the study objectives was to explore how the aged survive in terms of their activities as part of their daily lives; respondents were expected to perform some activities at home. They were asked to indicate which of such activities they could do without help, with help or could not do at all. As has been indicated in table 6, 16 activities were listed. It was observed that respondents could perform most of the activities on their own or sometimes with some help. However, preparing own meals, going to market or shopping, washing and cleaning of items and going to places out of home seemed quite strenuous to some of them as some physical effort was needed to complete such activities.

The research also sought to understand the coping mechanism adopted by the aged in the Metropolis with certain specific activities which they needed to perform as part of their daily living. They were asked to indicate activities they could perform without assistance, activities they could perform with some assistance and activities they could not perform at all. Sixteen items were identified as activities which they needed to perform as part of their daily living.

Table 6: Performance of activities of daily living [n = 140]

Activity	Can do all	With help	Unable	Mean score
Getting in out of bed	96.4	3.6	0	2.96
Dressing and undressing	97.1	2.9	0	2.97
Deciding what to wear	96.4	3.6	0	2.96
Going to the wash room on time	92.1	7.9	0	2.96
Taking own bath	95.7	4.3	0	2.96
Doing household chores	96.3	30.0	0.7	2.70
Taking care of own physical appearance	89.3	10.0	0.7	2.90
Preparing own meals	50.4	44.0	5.6	2.50
Deciding what to eat	84.4	12.8	2.8	2.83
Eating on their own	88.6	9.3	2.1	2.88
Washing/cleaning items	48.3	46.9	4.9	2.47
Walking around the house	87.1	11.4	1.4	2.87
Going to places out of home	79.3	12.1	8.6	2.73
Going to market/shopping	50.3	35.2	14.5	2.38
Keeping own money	95.0	4.3	0.7	2.94
Taking medicine on their own	75.7	20.7	3.6	2.73

Note: A score of 3 was given for activities performed without help; 2 was given for activities in which the aged needed some help; while a score of 1 was given for activities in which the aged was unable to perform.

Source: Field survey, 2003

It was observed that although the aged in the Cape Coast Metropolis were capable of performing almost all the activities on their own without any help at all or sometimes with some minimum support, there were a few activities they could not perform on their own. These activities included: cleaning, washing, shopping

or going to the market, going to other places out of home and preparing their own meal. These activities were quite strenuous and so demanded some physical efforts in getting them done. Regular supportive services seemed necessary as a result. Kosberg (1994) observes that supportive services help the aged develop their full capacities in personal, social and community relationship and maintain a quality of independent living. Services such as provision of information on benefits and programmes for the aged and meals to aged either within or outside their homes seem necessary. He further observes that mental health, counselling and social work services are essential for the well-being of the aged. In Japan for instance, four major community care services are by law provided for the aged. They include home help, day care, respite care and provision or rental of special appliances (Shimizu and Wake, 1994: 237-239).

Home help services enable aged 65 years and above to remain at home while personal care and home making services are provided. This helps keep family intact. Services include: laundering, shopping and preparation of meals and some personal care including bathing. Considering the fact that there were five activities which the aged in the study found very difficult doing even with some assistance, home help services could indeed be a great relief to them. Again, day care services could also be necessary for the aged who felt they were too old and weak; this could also minimize the burden of family caregivers.

Legally articulated in the amended law of the welfare of the aged in 1990, Japan's day care centres provide; (i) core services, including information and advice, rehabilitative activities for daily living, health check ups, and

transportation; (ii) optional provision, including bathing and meal services; (iii) optional home-delivery provision, including bathing, meals and laundry services and (iv) sending of care workers to housing for senior citizens (Shimizu and Wake, 1994:237).

The fact that the youth these days tend to withdraw from the care of the aged and concentrate on the nuclear family owing to limited house space and time, as Banga (1989) observes, makes day-care services very important especially for the very frail and the disabled aged. This will provide some relief for children, the main caregivers so that they could also concentrate on other responsibilities. Sometimes, owing to social matters, such as illness or attendance at public occasions, family caregivers may not provide care at home (Shimizu and Wake, 1994:237).

The services are provided at accredited facilities, such as nursing homes and homes for the aged. This could be a great relief again for children who need to travel out of town to work and come back only on week ends or at the end of the month. Respite care also provides night care services for severely demented aged who require constant care during the night. Again, caregivers who attend night duties will find such services quite convenient since they could then concentrate on their duties without bothering so much about the aged parents left behind.

The programme, which provides or rents special appliances for disabled aged and their families could also ease caregivers and improve their quality of lives. The special beds and bath tubs could for instance provide some comfort for

the aged. Wheel chairs could also improve movement of the frail and disabled aged at home and within the community. This could also promote and improve socialization among families and neighbours and remove boredom among such aged persons.

Testing the research hypotheses

The summary of results of the hypotheses is provided in this section. In order not to arrive at any unjustifiable conclusion, the field data was subjected to rigorous test, using the Chi-Square Test, (X test). (Assumptions and results of the tests are in Appendix D).

According to the first hypothesis, the aged whose medical bills are paid by their children are more likely to be dissatisfied with their payment arrangements than the aged whose medical bills are paid by others. The results are provided in Table 7.

Table 7: Satisfaction of payment of medical bills [n = 140]

Payment of medical bills	Aged without children percentage	Aged with children percentage	Total percentage
Self/others	100.0	52.6	57.8
Children	0.0	47.4	42.2
Total	100.0	100.0	100.0

*The total is more than the number of respondents due to multiple responses.

Source: Field survey, 2003

The test shows that the observed value was more than the critical value. The Null Hypothesis is therefore, rejected in favour of the alternative since the aged whose medical bills are paid by their children are more likely to be satisfied with their payment arrangements than the aged whose medical bills are paid by others. In Table 7, 47.4 percent aged with children indicated that their medical bills were paid by their children, while only 11.4 percent aged without children indicated that their medical bills were paid by themselves or others. There is, therefore, a significant difference in the payment of medical bills between aged with children and aged without children.

The second hypothesis states that: the aged who continue to live with children are more likely to be dissatisfied with the quality of their accommodation than the aged who are living with others. The results are presented in Table 8.

Table 8: Satisfaction of quality of accommodation [n = 140]

Level of satisfaction	Living with		Total percentage
	Children percentage	Others percentage	
Satisfied	90.0	52.5	68.4
Not satisfied	10.0	47.5	31.6
Total	100.0	100.0	100.0

(* The total is more than the number of respondents due to multiple responses.)

Source: Field survey, 2003

The test shows that the observed value is greater than the critical value. We, therefore, reject the Null Hypothesis which state, the aged who continue to live with children are more likely to be dissatisfied with the quality of their accommodation than the aged who are living with others.

In Table 8, 90 percent of the aged who lived with their children expressed satisfaction with the quality of accommodation. Only 10 percent said they were not satisfied with their accommodation. Comparatively, only 52.5 percent of aged expressed the same sentiment with the quality of their accommodation provided by others. Also, as many as 47.5 percent indicated their dissatisfaction with the quality of accommodation provided by others.

With regards to the third hypothesis, the aged who continue to receive support for meals from their children are more likely to be dissatisfied with their meals arrangements than those who do not receive any support from their children. The results are provided in Table 9.

Table 9: Satisfaction of provision of means for meals [n = 140]

Level of satisfaction	Living with		Total percentage
	Children percentage	Others percentage	
Satisfied	94.7	77.0	82.7
Not satisfied	5.3	23.0	17.3
Total	100.0	100.0	100.0

(* The total is more than the number of respondents due to multiple responses.)

Source: Field survey, 2003

The test shows that the observed value is higher than the critical value. We, therefore, reject the Null Hypothesis that, the aged who continue to receive support for meals from their children are more likely to be dissatisfied with their meals arrangement than the aged who do not receive support from their children.

In Table 9, 77.0 percent of the aged who received support from others for their meals expressed satisfaction with their meals. However, 94.7 percent of the aged whose children provided the means for their meals also expressed satisfaction with their meals arrangement. It is relevant, therefore, to state that the aged who continue to receive support for meals from their children are more likely to be satisfied with this arrangement than the aged who receive such support from others.

Perceptions and reactions to social support

Contributions of the aged towards the upkeep of the home

The study discussed that a number of the aged made some contributions towards the upkeep of the home. Their contributions ranged from financial support (21.6%), pieces of advice (41.7%), part of the decision-making machinery at home (30.3%) and other (1.4%) contributions. However, there were others (5.0%) who made no contributions at all.

Table 10: Contributions of the aged towards the upkeep of the home [n = 140]

Contribution	Percentage
Money	21.6
Pieces of advice	41.7
Part of decision-making machinery	30.3
Other	1.4
Not at all	5.0
Total	100.0

(*The number was more than the number of respondents due to multiple responses.)

Source: Field survey, 2003

Contributions of the aged in the community

The research also explored whether despite their vulnerability, the aged were supportive of community development efforts. It was observed from the results (Table 10) that the aged offered support to the community. This included financial contributions (22.8%), pieces of advices (27.5%), part of the decision-making machinery (32.3%) and other (4.8 %) contributions. Some (12.6%) however, did not make any contributions at all.

Table 11: Contributions of the aged in the community [n = 140]

Contribution	Percentage
Money	22.8
Pieces of Advice	27.5
Part of decision-making machinery	32.3
Other	4.8
Not at all	12.6
Total	100.0

(* The total is more than the number of respondents due to multiple responses.)

Source: Field survey, 2003

Perception of the aged at home

The investigations carried out by the researcher revealed that in the home, the aged were honoured (41.2%) dignified (18.7%) and considered resourceful (31.0%). Only a few were perceived as burdensome (5.9%), outcast (1.6%) and a disgrace (1.6%) to the home.

Provision of social support for the aged

The majority of the respondents (67.7 %) thought their children should be responsible for the provision of their needs. However, some 21.8 percent were of the view that they themselves should be responsible for the provision of their own needs. Other respondents felt relatives (3.7%), government agencies (3.7 %),

others (2.4 %) and spouses (.7 %) should have supported in the provision of their needs.

Rating of social support by respondents

In rating the social support available to them, a few (5.7 %) indicated that it was excellent. Some 27.9 percent also said it was very good, but the majority of respondent (34.3 %) felt it was good. Also, some 25.0 percent were of the view that it was satisfactory. Very few aged (7.1 %) indicated that it was poor.

Table 12: Rating of social support by respondents [n = 140]

Rating	Percentage
Excellent	5.7
Very good	27.9
Good	34.3
Satisfactory	25.0
Poor	7.1
Total	100.0

Source: Field survey, 2003

Results of the analysis suggest that the aged were resourceful, both at home and in the community. To improve upon the use of their leisure-time, they offered pieces of advice, participated in decision-making processes and sometimes offered financial or material support for the upkeep of the home in particular and the community in general. In other parts of the world, such as

China, the aged live with their children and grand children after retiring from active service. They help with housework, take care of grand children and enjoy family life (Wenmei, et al 1994:89). Also, in Hong Kong, the aged serve as volunteers for frail and the handicapped aged in the community (Chow, 1994:184). In Argentina, however, the aged are prone to spend most of their leisure time in activities limited to the house and family with little community participation (Barca, 1994:10)). Sometimes, it may be necessary for the aged to improve community participation to remove boredom at home. The ultimate is to improve socialization, find pleasure and comfort as a way of improving their well-being. As a result of their support to the family and the community, the aged in the study area were honoured and dignified by the family and members of the community. They could therefore receive social support from children, spouses, relative and other members of the community.

A few aged were considered outcast and disgrace to the home and the community. As a result, securing social support was difficult. It seemed such aged did not have children or did not take care of their children or other members of their family when they were in active service. They were therefore neglected by their children or the family. Again, it seemed some of the aged did not offer any contributions towards community development and as such, did not have the sympathy of the community in the provision of support such as remittances and visits when sick. Where such support existed, they were just negligible: a support which will merely guarantee their survival.

The results discussed above find expression in the conceptual framework used in the study. The underlying assumption of the framework is that social support for the aged is a function of the contributions of the individual aged, the family and society. It further identifies some of the contributions as care for children, and other members of the extended family and provision of material and moral support to communities within which the aged live. Such contributions determine the quality and quantity of social support which influence the outcome of the support; either positive or negative to the well-being of the aged as illustrated above. Whatever the situation, society should show sympathy and forgiveness under the circumstance and express love and show concern for old age

Traditionally, the aged thought their children should be responsible for their care and support. However, the fact that majority of them (66.4%) rated social support as good, satisfactory or poor suggested that all was not very well with them. They needed better carers to improve their well-being. Understandably, the fact remains that with limited home space, income and time, the youth these days tend to withdraw from the care of the aged and concentrate on the nuclear family (Banga, 1989). There was therefore the need for a reliable alternative support system to sustain and improve the quality of lives of the aged.

Again, the framework identifies an emerging organised support system which supplements the contributions of the family and the local community. These are non-governmental organisations and government policies and actions. This has been confirmed by the results of the study where a few (3.7%) suggested,

that NGOs and Faith Based Organisation could help improve support. More importantly, over 70 percent of respondents identified government intervention as a necessity as a way of improving social support. Thus, there is need for explicit government policies and programmes on social support for the aged as identified in the statement of the problem of the study as a way of ensuring improvement of the well-being of the aged.

Improving the social support for the aged

Over 70 percent of respondents were of the view that government should intervene to provide their needs as a way of improving the current social support system. A little over 12 percent felt the community should improve their well being. However, a few (5.5 %) thought improvement should be made by their own children, the aged themselves (3.7 %), NGOs, churches and other benevolent organisations (3.7 %). The rest (4.2 %) said they had no ideas or suggestions to offer.

The over 70 percent respondents who called for government intervention in the improvement of the social support for the aged made a number of suggestions. Majority (50.4 %) said the government should provide all the necessary social amenities. Others (15.5 %) indicated that government should provide social centres for entertainment for the aged. Some 11.1 percent also thought government should provide homes for the aged, provide free medical care for them (9.4 %), provide capital to reactivate or establish their own businesses (8.4 %) and increase the pension paid to former government employees (5.2 %).

Table 13: Improving the social support for the aged [n = 140]

Type of Improvement	Percentage
Provision of social centres for entertainment	
by government	11.0
Provision of free medical	6.7
Establishment of aged homes by government	7.9
Provision of social amenities by government	35.4
Provision of capital by government for investment	6.0
Increased pension by government	3.7
Increased support from children	5.5
Support from NGOs and religious organisations	3.7
Increased support from the community	12.2
Increased effort by aged themselves to provide for themselves	3.7
No idea/No advice	4.2
Total	100

(*The total is more than the number of respondents due to multiple responses.)

Source: Field survey, 2003

Realising that they could no longer rely on the family alone for their needs, the aged were of the view that formal support should be the best alternative. In most countries of the world, history indicates that family care of

the aged has been the main method by which the need of the aged has been met. However, family caregiving cannot be viewed as a panacea (Kosberg, 1994). For a variety of psychosocial, physical or economic reasons, family members may be ill-suited and inappropriate for care giving responsibilities. For instance, some families may be unavailable or live great distances away from home (Kosberg, 1994).

As a result, the respondents observed that there is often the need for mechanisms, other than the individual or family to provide needed assistance to them. It therefore came as no surprise, when respondents indicated that such an intervention should be provided by government with the active support of the private sector such as NGOs and religious organisations.

As Kosberg (1994) puts it, the providers, whether financial, psychosocial or physical, can come from public or private sector, towns, cities or other local communities; by districts, or regions; or by national or federal governments. Private resources could be based upon religious, fraternal, tribal, and ethnic or other such characteristics. Kosberg (1994) is also of the view that countries can of course reflect and often do a combination of private or publicly sponsored resources for those in need. It is therefore necessary under the circumstance that respondents find themselves, that government provides an explicit policy for the provision of social support for the aged. In such policy, eligibility criteria must be met to receive programmes, services and benefits. As Kosberg (1994) observes, eligibility might be based upon economic, health and psychosocial conditions. Also, vulnerability or high risk related not only to the present condition of older

persons but also to a high probability that adversity will occur to them are other considerations. The policy may consider income maintenance and employment, healthcare, housing resources, supportive services, leisure-time resources, advocacy and protection, among others. Considering the areas mentioned above, such a policy should see the private sector as an active partner in the provision of social support for the aged.

To improve social amenities in the community for the provision of good health and disease prevention among others, housing arrangements, especially for the aged seem necessary. In this area, social settings available for the aged and assistance for maintaining them in the dwellings of their families need to be given attention. Such amenities as potable drinking water, reliable lighting system, efficient transportation system and good health facilities are necessary for the promotion of good health, prevention of disease and maintenance of the general well-being of the aged. This demands that national housing policies and programmes and development of private housing industry meet the housing needs of the aged

Another area of concern expressed by respondents was the establishment of an old age centre by the government. The centre should provide good grounds for socialization and a place to address their health and other essential needs. To remove boredom and loneliness and to avoid monotony of activities outside the home, such a centre could provide recreational facilities such as ludo, oware and draught, as well as a library and other educational and social programmes to

improve the use of their leisure-time. The aim is to socialize, find pleasure, happiness and comfort, with the view to improving their well-being.

In recognizing the fact that they could not continue to depend on family care, the aged in the study also wanted government to provide them capital for investment in economic activities, while former government employees among them felt government had to increase the pension paid them. In some countries, government may not provide capital for investments, but could provide job opportunities for the aged to be re-employed as in Canada and South Korea where the aged are provided training and retraining opportunities to help them rejoin the work force. To encourage industries to hire the services of aged workers, an employer who employs aged workers above a recommended ratio could be given tax exemptions or tax reduction as done in South Korea under their Senior Citizens Employment Act of 1991 discussed under the literature review of Chapter Two.

Where the aged become too old and weak they are unable to work as indicated by some respondents in the study. Apart from the social security scheme which provides for retired workers in public and private sectors in Canada as in Ghana, the former also provides retirees with additional income primarily from government transfer payment. The details of which are discussed under the literature review. This strategy could be adapted to benefit the aged in Ghana.

In their call for improvement in social support, the aged identified very vital areas where formal support should address. Apart from their request for the establishment of a centre and improvement in social amenities, health facilities,

employment income maintenance and use of their leisure-time the aged also felt there were other essential needs which were necessary to improve their well being. Supportive services discussed under activities of daily living indeed seem to be one of such essential needs. Again, there has been an increasing awareness of the vulnerability of the aged persons to victimization in society. This could result from crime by strangers (on the street or within one's home), maltreatment within institutions (or within other formal service settings) and elder abuse (by family, friends, and neighbours) (Kosberg, 1994).

From this observation, an organised effort for advocacy and protection of the aged is indeed another essential need of the aged which needs mentioning. In this support, there are opportunities for legal assistance for advice on rights pertaining to such things as wills, contracts, policies (i.e. insurance, burial) and taxes and for victims assistance (Kosberg, 1994).

In Ghana however, there is no explicit policy to provide the public and private sectors, a common platform to forge partnerships as pertain in other countries. Where such a policy continues to elude the country, the situation in which the aged find themselves may deteriorate at a rate faster than expected. This is viewed against the unprecedented higher rates of modernization and urbanization where children seem so consummated in the maintenance of nuclear families. As Banga (1989), puts it, social change is fast weakening the fabric of the family support system as the main source of sustaining the aged.

Efforts by departments such as the Department of Social Welfare, Community Development and the Ministry of Health continue to remain

inadequate and uncoordinated in the absence of an explicit policy for the care of the aged. Again, the few NGOs, such as Help Age Ghana, are unable to provide enough to cater for the needy aged. Such formal efforts as advocated by respondents in the study could provide the much needed support where they are effectively co-ordinated and adequately resourced. In order to provide for all needy aged, such efforts should be extended from the national to the local levels of the society.

Indeed, where laws make it obligatory for the family to continue to play their traditional role as in India, it will be difficult for the informal support system to be eroded completely. Again, when formal support system is given the much needed consideration, efforts of the informal support system could be actively complimented. All of these will be committed towards the improvement of the living conditions of the aged and the restoration of their dignity. The aged will therefore be assured of an improved and sustained support which will provide for them a better future under the circumstance.

It is observed from the study that, with the mean number of children of respondents given as 5.45 and a standard deviation of 2.93, there is a wide disparity in the number of children among respondents. This is exemplified by the fact that one respondent had as many as 16 sons compared to 25 other respondents who had a son each. Again, one respondent had as many as 13 daughters as against 82 other respondents who had a daughter each. Where respondents had few children, their chances of getting support from children, the main care providers, seemed quite slim especially viewed against the fact that about two

children of each respondent were either learning a trade, going to school or unable to secure a job. Again, the other three children who were working might be committed to nuclear families; hence they might have little resources left to cater for their aged parents. It is therefore relevant to indicate that, indeed, formal support system should be given the due consideration as Banga (1989) indicates, as a way of improving social support for the aged, so that the future does not seem bleak for the aged as Apt (1996) suggests. Again, the fact that the world population is gradually aging makes this demand very timely and crucial especially as Ghana does not have any explicit policy on social support for its aged population.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The chapter provides the summary of areas considered in the study, the major findings and conclusions made from the analysis. This is followed with recommendations which are based on the findings from the study.

Summary

This study set out to understand the social support available to the aged in Ghana with Cape Coast Metropolis as the place for the investigation. The main objective of the study was to examine the social support system available to the aged. The specific objectives were to;

- Identify the type(s) of social support available to the aged in the Cape Coast Metropolis;
- Explain variations, if any, of the available social support systems;
- Investigate if of providers offer any social support to the aged;
- Assess the perceptions and reactions of the aged to available social and its adequacy; and
- Make recommendations for policy interventions.

The study was conducted in the Cape Coast Metropolis which comprised five zonal councils, namely; Efutu/Kokoado/Mpeasem; OLA/University/Duakor; Abura/Pedu, Aboom/Bakaano; and Amanful/Ntsin. Based on Ghana Statistical Service demarcation, the study area was stratified into urban and Peri-urban areas. The target population for the study were the aged 60 years and above. Data collection covered 140 selected respondents who were farmers, fisherfolks, professionals, administrative workers, self-employed and traders. Out of this total, 105 represented the urban area, while 35 represented the Peri urban area. Three data collection instruments were employed to solicit information for the study. These were interview schedule, observation and focus group discussion. The interview schedule and observation techniques were employed concurrently with the support of four field assistants and the researcher during the period of August – September, 2003. The focus group discussion was organised within the same period by the researcher who played the role of a moderator.

The data was processed and analysed using the SPSS programme. Some of the variables were subjected to statistical tests with a view to finding associations and relationships. This was to make well informed and reliable analysis for acceptable and relevant conclusions to be drawn.

Major findings

- The marital status of respondents indicated that 45 percent were married and continued to live with their spouses; 35 percent were widowed; 10.7 percent divorced; 7.9 percent separated; and 1.4 percent single.

- The respondents had a total of 719 children, comprising 370 sons and 349 daughters. On the average, each respondent had a total of 5.1 children, made up of 2.64 sons and 2.47 daughters.
- Over half (54.3%) of respondents had no formal education. However, 20.7 percent had middle school education, 5.7 percent had primary education while 4.3 percent attended technical school.
- Many respondents (37.2%) were fisherfolks, with the rest made of 21.4 percent professionals, 9.3 percent farmers, 5.7 percent administrative workers, 3.6 percent self-employed and 2.1 percent traders.
- In the urban area, respondents were mainly fisherfolks who used canoes for fishing. However, respondents of the peri-urban area were mainly farmers, using simple tools such as cutlasses, hoes and sticks for farming.
- None of the fishermen continued fishing as a result of weakness resulting from aging. On the other hand, 90.2 percent of farmers continued to farm.
- Many of the fishermen (87.4%) had resorted to lending fishing nets, repairing canoes and boats, painting as well as sand and stone winning for construction purpose.
- At the retiring age of 60, many of the respondents (46.4%) continued to work to make ends meet. The remaining 53.6 percent assigned various reasons for not working any longer including majority (39.6%) of them who indicated that they were too old to work.
- On the whole, most of the aged could perform most activities of daily living on their own, with general score ranging from 2.38 to 2.96.

- However, going to the market or shopping, going to places out of home, washing and cleaning of items and preparing own meals which seemed quite strenuous to some of them as some physical effort was needed.
- The informal social support system was the main support system available for respondents. Social support received by respondents included cash remittances, feeding, clothing, information flow, accommodations, medication and visits when sick. The main providers were children (36.1%), with daughters (18.4%) playing the leading role. However, spouses (11.3%), relatives (15.4%) and friends (5.5%) also provided some support.
- (ix) In rating the support available to them, some 34.3 percent of the respondents felt it was good, 27.9 percent said it was very good, satisfactory (25.0%) and excellent (5.7%).
- Regarding the provision of social support, majority (67.7%) felt their children should continue to take up responsibility. However, some 21.8 percent were of the view that they themselves should be responsible for providing their own needs. Other respondents thought relatives (3.7%), government agencies (3.7%) and spouses (0.7 percent) should support in the provision of their needs.
- Recognising that their children could not continue to take responsibility of their needs owing to children's responsibility to nuclear families and also, observing their inability to provide all their needs on their own, most

respondents (70.7%) were of the view that government should intervene to provide their needs as a way of improving social support.

- Among the suggestions to improve future living of the aged were the needs for government to provide social centres for their entertainment provide homes and free medical care to cover all ailments, provide capital to reactivate or establish their own enterprises and increase the pension paid to former government employees.
- The results of the three (3) hypotheses tested indicated that most children paid the medical bills of the aged parents provided good quality accommodation for them and ensured that means were provided for their meals.

Conclusions

Based on the main findings of the study, the following conclusions with respect to social support for the aged could be drawn.

- The informal social support system is the main support system available to the aged in the Cape Coast Metropolis. This is supported by the results of the three (3) hypotheses tested which indicated that most children pay medical bills provide good quality accommodation and means for the meals of their aged parents.
- The major responsibility of care for the aged has shifted from the extended family to the nuclear family, where daughters play a leading role. Also

aged themselves are the next major providers of their own support after the nuclear family. However, the extended family support comes third.

- There is inadequate social support to the aged especially with regard to cash remittances and visits when aged are sick. The aged also realise that they cannot continue to rely on their children at all times for the needed support. This is also viewed within the context of the desire of the aged to continue working even at the retiring age and their demand for improvement of social support generally,
- Fishing seemed so strenuous that aged fishermen cannot go fishing anymore. They therefore resort to less strenuous work such as mending fishing nets, repairing canoes and boats and sand and stone winning for construction purpose. However, farming seemed less strenuous than fishing. As a result, many farmers continued to farm to make ends meet.

Recommendations

Given the complexity of supporting people at old age and the many stakeholders at play, traditionally, caring for the aged the world over is supposed to be the responsibility of the family, friends, neighbours and members of community such as a village or a clan. In many countries it is supported by special institutions (Kosberg, 1994). Indeed, the study has also proven that the provision of social support for the aged is a shared responsibility where the family, community, non-governmental organisations, other institutions and government need to co-ordinate activities to make meaningful and considerable

contributions towards the provision and improvement of social support for the aged. For a sustainable social support, therefore, the following recommendations are directed at different levels of support and among various stakeholders:

Role of family

- In order that the family continues to play its traditional role of providing social support for the aged effectively, its financial base needs to be improved. In view of this, income tax relief should be given to member workers who can prove that they contribute a given percentage of their income for the needs of their aged members.
- To provide capital to reactivate or establish their own businesses, financial assistance in the form of loans should be granted care providers of the needy aged by the District Assembly or financial institutions for the purpose. Where necessary, such loans should be given to the aged directly to undertake their enterprises. Organised aged groups should also be encouraged to form co-operatives to be given loans for economic ventures to earn a living for their members.
- To preserve the family's traditional role of providing social support for the aged, public education in the form of talk shows, seminars, community durbars among others should be organised by District Assemblies, religious bodies, NGO`s and CBO`s regularly from the national to the local levels. This is to raise and sustain awareness of care for the aged

working parents, should also be educated to be more responsible to their children in order to enjoy some social support from them at old age.

Role of community

- The community should give recognition to the role of Community Base Organisations (CBOs) and NGOs by collaborating with them in the provision of the needs of the aged in the community
- It should show appreciation for contributions made by the aged in cash or in kind towards the maintenance and development of the community. The involvement of the aged in decision-making towards the development of the community will encourage them to share their rich experiences with the youth. The opportunity will also help remove stress, isolation, loneliness and neglect which characterise the aging process, thus, promoting psychosocial care for the age.
- The community should encourage retirees of both private and government sectors to establish senior citizens associations at the national, regional, district and local levels to promote their welfare.
- CBOs, NGOs and other institutions should be encouraged to establish service centres for the aged in all major communities. The centre will combine and integrate the numerous services needed by the aged for their very survival. It should be a convenient place where they can get a package of services needed while they continue to stay at their various homes. Creation of residential facility should not be encouraged.

- However, where it becomes necessary for some of them, family ties should be maintained by encouraging family involvement in the programme. This is to ensure that the aged are always integrated in the society.

Role of government

- The government should provide an explicit policy on the provision of social support for the aged. A policy that will protect the interest of the aged and especially ensure that family members do not abandon their aged members.
- Government should co-ordinate all service delivery activities at the national, regional, district and local levels to ensure uniformity and orderliness in the provision of the support. This calls for the establishment of a department by government to be responsible for the aged.
- With the support of the private sector, the government should organise courses and seminars on the concept of aging and the processes of aging. Topics such as preparation towards retirement from active service, maintenance of the aged among others should highlight the importance of this segment of the population. Such programmes should also target the aged themselves. Here, the emphasis should be on the promotion of live-long education to improve their leisure and to encourage the re-use of their knowledge and skills.
- The aged fishermen should be encouraged to form co-operatives through education so as to attract loans from both public and private financial

Institutions. They could therefore establish their own shops to provide services in fishing net mending and repairs of canoes and boats which are not quite strenuous. Also, building contractors should be encouraged to employ the aged in painting as well as sand and stone winning in the construction industry when given some tax exemptions as incentives for doing so.

- The aged farmers should also be encouraged to continued farming where government introduces modern farming techniques such as the use of fertilizers, improved seeds as well as tractors, ploughs and combined harvesters to improve yields.
- In recognition of the roles played by the aged in the society, the celebration of 'Senior Citizens' Day should be extended to all regions and districts. It should be a day for honouring the aged for their numerous contributions towards the development of the society, and
- Awards should be given to individuals, agencies, institutions and organisations which prove to protect the rights of the aged, improve their living conditions and restore their dignity.

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APPENDICES

APPENDIX A

INTERVIEW SCHEDULE FOR THE AGED

The purpose of this survey is to collect data on available social support for the aged in the Cape Coast Metropolis for study and analysis towards the promotion and improvement of their welfare.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Sex (a) Male (b) Female
2. Age (a) 60-64 (b) 65-69 (c) 75-79 (d) 80-84 (e) 85-89
(f) 95-99 (g) 100 and above
3. Marital status (a) Married [] (b) Divorced [] (c) Separated []
(d) Widowed [] (e) Single []
4. Number of children born alive (a) Sons.....(b)
Daughter(s).....
5. Number of children still alive (a) Sons..... (b)
Daughter(s).....
6. Age of children (a)son(s);
1st.....2nd.....3rd.....4th.....5th
6th..... (b) Daughter's 1st.....
2nd.....3rd.....4th.....5th.....
6th.....

7. Number of dependents.....
8. Ethnic background (a) Fante [] (b) Twi [] (c) Ahanta [] (d) Nzima [] (e) Ewe [] (f) Ga/Adangbe [] (g) Hausa [] (h) other specify..... Non-Ghanaian.
9. Highest level of education attained: (a) Primary School [] (b) Middle School [] (c) G.CE. O' Level [] (d) G.CE.A' level (e) Vocational Training [] (f) Technical Training [] (g) Teacher Training [] (h) Polytechnic [] (i) Non-formal education [] (j) University or equivalent [] (k) No education [] (l) Other specify.....
10. Highest level of education attained by children (a) Primary School [] (b) Middle School [] (c) J.S.S [] (d) G.C.E. O' Level [] (e) G.E.C.A Level [] (f) Vocational Training [] (g) Teacher Training [] (h) Polytechnic [] (i) University or Equivalent [] (j) Non Education [] (m) Other(s) Specify

SECTION B: SOCIO ECONOMIC CHARACTERISTICS

11. What was your main occupation before age 60?
 - a) Professional and Related Worker []
 - b) Administrative Worker []
 - c) Clerical and Related Worker []
 - d) Sales/ Service Worker []
 - e) Farming and Related Worker []
 - f) Fishing and Related Worker []

- g) Self Employed []
- h) Unemployed []
- i) Other Specify []
12. Are you working presently? Yes [] No []
13. If yes, please state type of work (refer to question 11 above).....
14. If no please state reason(s).....
15. Do you receive any cash remittance from anywhere? (a) Yes No []
16. If yes, what is /are the source(s) (multiple choices)
- a) Son(s) []
- b) Daughter(s) []
- c) Friend(s) []
- d) Spouse []
- e) Pension scheme []
- f) Relation(s) (Specify []
- g) Institution/Organisation (Specify) []
- h) Own investment(s) (specify) []
- i) Other(s) (Specify).....
17. How many of your children are working at the moment?
- a) Son(s).....
- b) Daughter(s).....
18. How many are responsible to children/couple(s)
- a) Son(s).....
- b) Daughter(s).....
19. How many did you look after?
20. How did you do that (Multiple choice)
- a) Provided basic needs (i.e food, shelter, clothing healthcare) []

- b) Paid school fees and other education materials []
- c) Provides some pieces of advice []
- d) Provided nothing []
- e) Other (Specify).....

21. If you did not take responsibility, please state reasons(s)

- a) I had no means []
- b) Wife/fiancée had an affair with another man []
- c) Wife/fiancée was rude to me []
- d) Wife/fiancée had an affair with another man []
- e) Wife/fiancée was rude to me []
- f) Parent of wife/fiancée did not allow me to marry wife/fiancée []
- g) Other (specify)

SECTION C: AVAILABILITY OF SOCIAL SUPPORT/ACCOMMODATION

/ LIVING ARRANGEMENT

1. Who lives with you in this house?

- a) House help []
- b) Friend(s) []
- c) Son(s) []
- d) Daughters(s) Spouse []
- e) Relatives []
- f) Other (Specify).....
- tenant(s)

2. If you do not live with spouse, Son(s) and Daughter(s), kindly explain briefly.....

3. Who owns this house?

- a) Myself[]
- b) Spouse[]
- c) Son(s) []
- d) Daughter(s) []
- e) Family[]
- i) Other Specify.....
- f) Friend[]
- g) Rented house[]
- h) Institution/Organsiasiati on (specify)

4. Who maintains the house/pays the rent/ (multiple choice

- a) Myself[]
- b) Spouse[]
- c) Son(s) []
- g) Other (Specify).....
- d) Daughter(s) []
- e) Relation(s) []
- f) Friends(s) []

5. If you did not/coul not build yur own house, please state reason(s)

- a) My wage/salary was too meagne to build a house[]
- b) I used my wage/salary to look after my children[]
- c) I used my wage/salary to look after my dependent(s) []
- d) It was not necessary because I stay in a family house[]
- e) I financially supported the construction of the family house so I was left with nothing to build my own []
- f) Other (Specify)

6. How do you find the quality of yuour accommodation?

- a) Excellent[]
- b) Very good[]
- c) Good[]
- d) Satisfactory[]

e) If not please explain

FEEDING

7. How many times do you eat daily?

- a) Since[]
- b) Two times[]
- c) Three times[]
- d) Four times[]
- e) Five times[]

8. Who provides the means for your meal(s)

- a) Myself[]
- b) Son(s) []
- c) Daughter(s) []
- d) Spouse[]
- e) Relation(s) []
- f) Friend(s) []
- g) Institution(s)
Organisation(s)
Specify
- h) Other specify[]

9. How do you find this arrangement?

- a) Excellent[]
- b) Very good []
- c) Good[]
- d) Satisfactory[]
- e) Poor[]

10. Please explain.....

11. Who prepares your meals(s)

32. Who prepares your meal(s) (a) Myself [] (b) Son(s) [] (c)

daughter(s) []

(d) Spouse [] (e) relation(s) [] (f) friends [] (g) institution(s)
organization(s)

(Specify)..... (h) Other
(Specify).....

33. How do you find this arrangement? (a) Excellent [] (b) very good
[] (c) good [] (d) Satisfactory [] (e) poor [] if (e) please, explain.....

34. If you do not take three square meals, please give reason(s) (a) I do not
have the means []

(b) I do not have the time to prepare it/them [] (c) I do not like to
take it/them [] (d) I do not have anyone to prepare it/them for me []

(e) Other (Specify)

35. Are you well fed? (a) Yes [] (b) No []

CLOTHING:

36. Who provides you with your clothing? (a) Myself [] (b) Son(s) [] (c)
daughter(s) []

(d) Spouse [] (e) relation(s) (f) friend(s) (g)
institution(s) (Specify).....

37. How often do you provide/are you provided?

Monthly	Si-monthly	Annually	Bl-annually
a. Self []	[]	[]	[]
b. Son(s) []	[]	[]	[]
c. Daughter(s)[]	[]	[]	[]
d. Spouse[]	[]	[]	[]
e. Friend(s)[]	[]	[]	[]
f. Other(s).....			
.....			

38. How do you find this arrangement? (a) Excellent [] (b) very good []
 (c) good [] (d) Satisfactory [] (e) if poor, please explain.....

HEALTH:

39. Do you see yourself as (a) Very health [] (b) Private hospital/Clinic []
 (c) Fairly health [] (d) Not health [] (e) Do not know []

40. Where do you go for treatment whenever you are ill?
 (a) Government hospital/Clinic [] (b) Private hospital/Clinic [] (c)
 Herbalist [] (d) Traditional healer [] (e) Spiritual [] (f) Herbalist []
 (g) Other (Specify).....

41. Why do you decide to go to this place for treatment?
 (a) Because I do not have enough money to see a medical doctor []
 (b) Because it is more effective than any other place of treatment []
 (c) Because it is closer to my house []
 (d) Because there is no alternative in the vicinity []

(e) Other (Specify) []

42. What is/are your main ailment(s)?.....

43. Is it/are they chronic? (a) Yes [] (b) No []

44. Who pays for your treatment? (a) Myself [] (b) son(s) [] (c) daughter(s) []

(d) Spouse [] (e) Relations(s) []

45. How do you find the quality of treatment? (a) Excellent [] (b) very good []

(c) Good [] (d) Satisfaction [] (e) if poor, please explain.....

46. Who visit(s) you when you are ill? (a) Son(s) [] (b) daughter(s) (c) Spouse(s) [] (d) Relation(s) [] (e) friend(s) [] (f) No visitor(s) []

(g) Institutions(s) Organization(s)

Specify..... (h) Other (specify).....

SOURCE OF INFORMATION:

47. Which of the gadgets do you have access to, who provides them (multiple choices) (a) Television Set [] (b) Radio Set [] (c)

Compute [] (d) Telephone [] (f) Other

(Specify).....

48. Why do you not have access to the rest?

Television Radio Video Computer Telephone

(a) Son(s) house [] [] [] [] [] []

- (b) Daughter(s) house [] [] [] [] []
- (c) Spouse(s) house [] [] [] [] []
- (d) Relation(s) house [] [] [] [] []
- (e) Friends(s) house [] [] [] [] []
- (f) Institution(s)/Organization [] [] [] [] []
- (g) Other (Specify).....

49. If you do not have access to any of them, please explain.

- | | Television | Radio | Video | Computer | Telephone |
|---------------------------|------------|--------|--------|----------|-----------|
| (a) Not necessary | [] | [] | [] | [] | [] |
| (b) Cannot find | [] | [] | [] | [] | [] |
| (c) Far from home | [] | [] | [] | [] | [] |
| (d) No knowledge of usage | [] | [] | [] | [] | [] |
| (e) Other (Specify)..... | | | | | |

50. How do you access to the following?

- | | Newspaper(s) | Magazine(s) | Book(s) | Premedical(s) |
|------------------------------|--------------|-------------|---------|---------------|
| (a) By Myself | [] | [] | [] | [] |
| (b) Son(s) | [] | [] | [] | [] |
| (c) Daughter(s) | [] | [] | [] | [] |
| (d) Spouse | [] | [] | [] | [] |
| (e) Relation(s) | [] | [] | [] | [] |
| (f) Friend(s) | [] | [] | [] | [] |
| (g) Institution(s)Org.[] | [] | [] | [] | [] |

51. What is/are your other source(s) of information?

- (a) Son(s) [] (b) Daughter(s) [] (c) Spouse [] (d)

Relation(s) []

- (e) Friend(s) [] (e) Institution(s)/Organization(s) (Specify)...

- (g) Other (Specify).....

52. How do you access your reading material(a) [] (a) Excellent [] (b)

very good []

- (c) Good [] (d) Satisfactory [] (e) Poor [] (f) Please,

explain.....

SOCIALIZATION:

53. How regular do you meet with the following (use the lettering attached to each period to indicate in the blank space provided where applicable, e.g. son(s) a for daily visit of son(s))

- (a) Daily (b) Every other day (c) Weekly (d) Bi-weekly (e) Six monthly (f) Annually (g) Not at all (h) Other (Specify).....

1. Sons(s)..... 2. Daughter(s)... 3.

Spouse(s).....

4. Son(s)..... 5. Friend(s)..... 6. Spouse(s).....

54. If not at all state reason(s) (a) No means of/for transport [] (b)

Too weak to attend meetings [] (c) Other (Specify).....

55. How regular do you meet with the following (apply as in question..... above)

1. Church association..... 2. Pensioners association.....
 3. Old Boys/Girls association..... 4. Unit Committee.....
 5. Watch Cog Association..... 6. Other (Specify).....

SECTION D: ACTIVATES OF DAILY LIVING

As human beings, we have to perform certain activities daily or regularly as part of our daily Lives. Kindly indicate which one(s) you can do without help, with help or unable to do at all.

	Can do all	With help	Unable
1. Getting/out of bed	[]	[]	[]
2. Dressing and undressing	[]	[]	[]
3. Deciaing what to wear	[]	[]	[]
4. Going to the washroom on time	[]	[]	[]
5. Taking your bath	[]	[]	[]
6. Doing your house work	[]	[]	[]
7. Taking care of your physical appearance[]	[]	[]	[]
(E.g. comb your hair)			
8. Preparing own meals	[]	[]	[]
9. Decides what to eat	[]	[]	[]
10. Eating on your won	[]	[]	[]
11. Washing/cleaning items	[]	[]	[]
12. Walking around the house	[]	[]	[]

13. Going to places out of walking distance from home [] []
[] []
14. Going to the market/shopping [] [] []
15. Keeping own money [] [] []
16. Taking medicine on your won [] [] []

**SECTION E: PERCEPTION OF SOCIAL SUPPORT BY THE
RESPONDENT**

57. How are you perceived in the house? (a) About cast [] (b) a burden []

(c) a disgrace [] (d) an houour [] (e) a dignity [] (f)
resourceful []

58. In your own opinion, who do you think should provide your need?

- (a) Self [] (b) children [] (c) relation(s) [] (d) spouse []
(e) friend(s)

60. (f) Government (specify.....) (g) Other (Specify)How in
your opinion can social support be improve to enhances the welfare of the
aged?

.....
.....

61. What contributions (s) if any, have you made/do you make to the
following: (multiple choice)

- a. House
 - b. Money []
 - c. Part of decision making machinery []
 - d. other (Specify)
 - e. Not at all []
62. did you prepare for old age? (a) Yes [] b. No []
63. What pieces of advice will you give the following class of people about old age?
- a) The Youth
 - b) The Working class:
 - c) The aged
64. How does it feel to be an aged person? (Multiple choice)
- a. Dignified [] b. honoured [] c. respected [] d. rejected []
 - e. Saddened [] f. dejected []
 - g. Other (specify)

APPENDIX B

BRAIN STORMING SESSION GUIDE FOR SOURCES AND TYPES OF SOCIAL SUPPORT AVAILABLE FOR MEMBERS OF GHANA PENSIONERS ASSOCIATION OF CAPE COAST

- A. General issues:
- i) How has social, religious and economic activities in their communities affected social support for them (PROBE)?
 - ii) Have such activities changed within the last 10 years?
 - iii) Is social support adequate or inadequate for them?
 - iv) If inadequate, let them give reasons and discuss how it can be improved?

APPENDIX C

OBSERVATION GUIDE FOR PHYSICAL APPEARANCE OF RESPONDENT AND THE SITUATION OF THE COMPOUND

During the interviews, the researcher and his assistants used the occasion to look round the physical environment of respondent to make the following observations;

- 1) How tidy the compound seemed to be.
- 2) How healthy and strong the respondent looked.
- 3) Whether respondent was well dressed or otherwise.
- 4) Whether or not care givers were available to offer support in some activities of daily living at the time of interview (name them).

APPENDIX D

RESULTS OF HYPOTHESES TESTED

1. Hypothesis I

The test showed the following results;

$$X^2 \text{ observed} = 5.226$$

$$X^2 \text{ critical value (0.05)} = 3.841$$

$$X^2 \text{ observed} > X^2 \text{ critical value}$$

2. Hypothesis II

The test showed the following results;

$$X^2 \text{ observed} = 33.768$$

$$X^2 \text{ critical value (0.05)} = 3.841$$

$$X^2 \text{ observed} > X^2 \text{ critical value}$$

3. Hypothesis III

The test showed the following results;

$$X^2 \text{ observed} = 8.488$$

$$X^2 \text{ critical value (0.05)} = 3.841$$

$$X^2 \text{ observed} > X^2 \text{ critical value}$$