Living Arrangements, Socio-Demographic and Health Conditions of Ghana's Elderly Persons: Results from 2006 Focus Group Discussions

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ABSTRACT

Aim
A pilot study was carried out to explore the living arrangements, health and socio-economic conditions of Ghana's elderly population with particular reference to one urban slum in Greater Accra Region (Old Fadama) and one rural HIV/AIDS endemic locality in Eastern Region of Ghana (Fanteakwa) for possible policy interventions.

Methods
Focus group discussions were held for two weeks in October 2006 with a view to unearthing important information relating to persons aged 60 years and above.

Results
The results suggest that changing social and economic circumstances do not seem to have eroded the traditional roles of the elderly at the family level. Some felt that they were compelled by circumstances to take care of their grandchildren, others thought it was a cultural obligation to take care of younger relatives. Most were not living with their adult children. Due to the death of their adult children or the migration of their adult children to cities and towns within and outside the country the elderly now contend with the double burden of fending for themselves and providing for the upkeep of their co-resident grandchildren. Looking over their lives from childhood till date, major shifts have been noticed in the living arrangements of the household; parents/children relationships; and position and authority of the elderly in the community. They were generally unhealthy and it was not easy assessing primary health care in their localities.

Conclusion
The findings have important implications for the health and well-being of the elderly in Ghana.

Key Words: Elderly persons, men, women, Ghana.

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Introduction and Rationale

Because the ageing phenomenon is occurring more slowly in Africa than elsewhere in the world and because Africa's populations are characteristically youthful we think the problems that are manifest among children and young adults are more significant. As a result, very little attention is paid to ageing in Africa by both the research community and policy makers while disproportionate consideration is given to other aspects of the age spectrum (e.g., infant and childhood, adolescence and childbearing ages).

Yet, the elderly are, arguably, more vulnerable because of lack of universal social security systems and fragmentation of families stemming from increasing economic hardship and stagnation and weakening of family organization and kinship networks in Ghana and many parts of the African continent (Mba 2004a; 2004b; 2001). Somewhat ironically, the same economic hardships that are leading to the abandonment of some elderly citizens are also calling for those who remain in families to be drafted more into care of their grandchildren as their own children succumb to economic pressures that take them out of the home for substantial periods of time or are increasingly afflicted by HIV. Yet, these elderly are not the most attuned to the modern health requirements; meaning that there are implications for the grandchildren they care for. The absence of the middle generation also means that the elderly who need care are frequently also looked after by adolescent grandchildren who are left at home to care for them. These developments have implications for the health and well-being of the elderly. Although central to the support system and well-being of the older population in Ghana is their living arrangements, very little information is available on this in the Ghanaian context (Mba, 2004a; 2004b).

The increasing difficulties of the elderly are frequently attributed to modernization and its attendant undermining of family structures and lineage systems. It is believed that

there is an inverse relationship between modernization and family support for the elderly, resulting in a growing incidence of low levels of well-being among the elderly persons (Mba, 2005; Asante, 2004; Ofstedal et al., 1999). Unfortunately, there is no empirical evidence to test this hypothesis in the Ghanaian context. Therefore, although the number and proportion of elderly persons in Ghana have been growing, it has been exceedingly difficult to investigate their living arrangements, largely due to lack of empirical evidence. Moreover, little is known about how changing residential conditions affect the socio-economic status of the older members of households in the country.

Against the backdrop of the foregoing considerations certain pertinent questions emerge: What are the survival strategies of the elderly in the face of changing social and economic environment? What is the tendency for extended kin, including adult children, to live with the elderly persons in these modern times? Do the elderly still receive financial support from their kin? To what extent has modernization eroded the traditional roles of the elderly? What is the health condition of the elderly? How has HIV/AIDS affected the elderly? In the light of these questions the specific aims of this study are to examine:

1. Means of livelihood of the elderly
2. Investigate patterns of living arrangements of the elderly by rural-urban place of residence
3. How various family structures influence the roles of the elderly in poor and non-poor homes
4. The general health condition of the elderly and how they are affected by HIV/AIDS.

Consequently, this study seeks to investigate the living arrangements of persons aged 60 years and over in urban and rural localities in two regions of Ghana, as well as their socio-economic and perceived health condition and quality of life for possible policy interventions.

In this connection a pilot study is being proposed to explore the living arrangements, health and socio-economic conditions of Ghana's elderly population with particular reference to one urban slum in Greater Accra Region and one rural HIV/AIDS endemic locality in Eastern Region of Ghana.

The results of the proposed study will demonstrate whether the changes currently under way in Ghana, precipitated by modernization, have altered the nature of the traditional household composition and the nature of the social and economic relationships within the family. It is expected that the findings of the research endeavour will be relevant for programme planning and policy initiatives at both governmental and nongovernmental levels. The relevant organizations will find the results helpful in identifying the vulnerable audience and hence the target subgroups for support and assistance.

Previous Studies

A plethora of research studies have been documented on the living arrangements of the aged in developed countries largely because population aging is already advanced in these countries (see, for example, United Nations, 1999b; United Nations, 1998; Lynch, 1998; Michael et al., 1980; Chevan and Korson, 1975; Sweet, 1972). In the developing world, analysts interested in population aging have focused attention primarily in Asia and Latin America. In their study, Asis and colleagues (1995) found that coresidence of elderly persons with one of their adult children is prevalent in developing countries because of the negative correlation between levels of kin coresidence and socio-economic development. It should be noted that there is mutual benefit derivable from kin coresidence. This is because while the elderly persons depend on the younger generation for financial, social, and healthcare support, the latter depend on the former to look after the home when they are away or take care of the younger children. Other studies on household size and composition, as well as

patterns of living arrangements and their socio-economic determinants with reference to the elderly persons in developing countries, include those of Mba (2005); Mba (2004a); Chobokoane and Zuberi (2001); Cameroon (2000); Palloni et al. (1999); De Vos (1998); Knodel and Chayovan (1997); Chen (1996); Martin (1989); Khasiani (1987); and Traore (1985). These studies reach the common conclusion that elderly persons prefer to co-reside with their kin, especially with their spouse and adult children. This condition provides a conducive environment for the care and support of the elderly persons.

But nothing is known about the impact of place of residence on the living arrangements of the elderly persons in Ghana. In particular, what difference, if any, does urban/rural residence in Ghana make for the likelihood that an elderly individual lives in an extended family household? Are the elderly persons who live in urban areas better-off than their rural counterparts?

Some researchers argue that the processes of modernization and urbanization are beginning to erode the traditional social welfare system of Africa, the extended family (Mbamaonyeukwu, 2001; Mba, 2001; Apt, 1996; Khasiani, 1987). In a typical African extended family unit, one readily finds elderly persons, adults, young people and children (Adeokun, 1981). One of the most important attributes of the traditional extended family is its potential for caring for the elderly population as a result of the social relations and interactions among kin groups, as well as roles and responsibilities different age groups assume. Unfortunately, very little is known concerning living arrangements, health, and socio-economic condition of Ghana's ever growing older population in this era of rapidly changing social and economic environment.

In a previous study, Mba (2004a) using the 1960-2000 census results of Ghana, as well as the 1988-1998 Ghana Demographic and Health Survey data examined the demographic and socio-economic characteristics of the rural elderly persons in Ghana, and

estimated the structure of future rural elderly population in Ghana on the basis of available evidence. With the anticipated rapid increases in the population of the elderly and the consequent greater potential need for food security and comprehensive social welfare services, it was necessary and urgent to gain a firm understanding of the demographic, social, and economic characteristics as well as the implications for poverty alleviation among the elderly persons in Ghana, with particular emphasis on rural areas where the phenomenon of population ageing is predominant. He found that both the number and proportion of the elderly to the total population have consistently increased for both sexes and for each sex. His findings further showed that the proportion of rural elderly persons rose markedly from 4.1% of the total population in 1960 to 7.9% in 2000, and that there were more elderly women than men in rural Ghana. Because his focus was on rural areas, he also found that overwhelming majority of these older people had no formal education and were engaged in agricultural activities (8 out of every 10 in each case). His projection results indicated that Ghana's rural population would rise from 10.6 million in 2000 to 22.1 million by 2050, while the proportion of the elderly people would increase from 7.9% to 15.7% (or from 838,000 to 3,461,000) over the same period. He argued that majority of the aged would be in the age range 60-69 years, and by 2050 Ghana's rural population would be an old population. He concluded that "…because of modernization and urbanization, the traditional solidarity network, particularly the extended family system, is disintegrating, leaving the elderly population with little or no means of support and care. As a result, Ghana's rapidly increasing elderly population is in a precarious situation that is likely to perpetuate poverty." (Mba 2004a: 90). But there was no empirical justification for this conclusion. The data he used were censuses and surveys that had other goals and objectives than specifically addressing these important issues concerning the elderly in Ghana. Another study generally looked at

the societal and economic implications of population ageing in Ghana on the basis of review of relevant literature (Mba, 2004b).

The welfare of the elderly in Ghana and most parts of Africa is considered to be primarily a family responsibility because only those in selected employment receive very limited social security benefits (Asante, 2004; Dixon, 1987). Unfortunately, studies on the older persons' living arrangement patterns and their determinants in Ghana, and Africa in general, are a rarity. It is therefore necessary to examine what type of household structure and patterns of living arrangements characterize the elderly persons, as well as the linkage between living arrangements and certain health and socio-economic characteristics in Ghana.

Data and Methods

The Regional Institute for Population Studies (RIPS), School of Public Health, and Korle-Bu Teaching Hospital, University of Ghana, Legon, Ghana in October (for two weeks) of 2006 embarked on a project aimed at examining the living arrangements, socio-demographic and health conditions of Ghana's elderly persons.

As part of this exercise, focus group discussions (FGDs) were held with a view to unearthing important information relating to persons aged 60 years and above in Ghana with particular reference to their living arrangements and coping strategies, as well as family and community roles in our rapidly changing social and economic environment; their care-giving and care-receiving roles in the era of HIV/AIDS; their general health condition, among others.

The pilot field study was conducted in two localities in Ghana, one rural area in Eastern Region, and one urban slum in the nation's capital city, Accra, in the Greater Accra Region. Given the nature of the research questions, coupled with time and monetary constraints, the investigators selected purposively the two localities in order to reflect not only the different infrastructure, culture and social contexts in rural and urban areas in Ghana,

but also to reflect varying socio-economic conditions, as well as experiences of and perspectives to health, access and use of primary health care services, in rural and urban Ghana. In this respect, Sodom and Gomorrha or Old Fadama (in Greater Accra Region) and Fanteakwa (in Eastern Region) localities were chosen purposively for the study.

Living arrangement was defined in terms of household family living. Attention was be focused on living alone and living with others (spouses, children, grandchildren, others).

A total of four FGDs were conducted, consisting of two per locality. In each locality, one FGD was held for each sex. Each FGD comprised 8-10 participants. In recruiting the FGD participants visits were made to the two localities to obtain permission from community and opinion leaders. Possible meeting places were identified and houses and dwellings that were not far from the meeting places were canvassed to identify elderly persons whose consent was sought for participation in the FGD. This process was followed until 8-10 males and 8-10 females were recruited in each locality. A consent form was completed by each FGD participant.

Majority of the elderly persons had little formal education. Consequently, it was difficult to accurately know the exact ages of many of them as very few have such records. In an attempt to plausibly estimate the ages of those who did not know their dates of birth, one of these three approaches was used: historical events list, reference to the oldest child (whose birth date is known), and a person in the household[4] or its vicinity who was an age mate to the participant and whose birth date was known.

The FGD questions were translated into *Ga* and *Twi*, and discussions were conducted in these local languages to elicit maximum participation from participants. The FGD questions essentially related to the older population's living arrangements, roles, care-giving,

[4] A household was defined in the study to consist of a person or individuals who live together in the same dwelling, share the same housekeeping arrangements, and are catered for as one unit.

care-receiving, self-reported health condition, health-seeking behaviour, HIV/AIDS, and what should be done to better the lot of the elderly population.

Findings

The background characteristics of the participants from the two regions are depicted in Table 1. Generally, participants came from the various categories of the elderly age group (60-69, 70-79, 80+) in the four FGDs, implying that all the categories of older population were represented in the discussions. Concerning educational attainment, with the exception of the male participants from Fanteakwa who had a substantial proportion attending middle school, overwhelming majority of the participants had no formal education. In Old Fadama, for example, except two male participants who had Arabic education, none of the male and female participants attended school. As an urban slum, this is unexpected due in part to pronounced poverty, culture and ignorance. Roughly all the participants had ever been married, supporting the widely held view that in Ghana, as in other parts of Africa, most women and men get married (Ghana Statistical Service et al., 2004).

Role of the Elderly in the Contemporary Familial Setting

The FGD participants from the four study locations were asked who they sat down to eat with (eating with spouse, co-resident children, others, etc.), what family outings they participated in and how, and whether they conducted casual conversation or discussed family events with their co-resident children. These questions were designed to find out their familial roles in contemporary times.

In general, both male and female participants were more attuned to separate eating as captured by a female participant from Fanteakwa:

"Each member of the family eats from his or her own plate. I serve my husband and the rest of the family members also eat from their own plates. I eat my food alone". (followed by a chorus affirmation from other participants).

Table 1: Characteristics of Focus Group Discussion Participants from Fanteakwa and Old Fadama, Ghana by Sex, 2006

Participants from Fanteakwa in Eastern Region					
Male			**Female**		
Age	**Educational attainment**	**Marital status**	**Age**	**Educational attainment**	**Marital status**
61	Middle school	Married	64	Primary	Married
62	Primary	Married	65	No education	Divorced
68	Middle school	Married	65	Middle	Married
68	Middle school	Divorced	70	No education	Divorced
71	Middle school	Divorced	71	Middle	Married
74	Middle school	Divorced	72	No education	Single
79	Primary	Married	75	No education	Divorced
81	Middle school	Married	78	No education	Widow
81	No education	Married	86	No education	Widow
90	Primary	Widowed	94	No education	Widow
Participants from Old Fadama in Greater Accra Region					
	Male			**Female**	
Age	**Educational attainment**	**Marital status**	**Age**	**Educational attainment**	**Marital status**
55	Arabic School	Married	60	No education	Married
59	No education	Married	62	No education	Married
61	No education	Married	62	No education	Married
63	No education	Married	62	No education	Married
65	No education	Married	65	No education	Married
72	Arabic School	Married	65	No education	Married
74	No education	Married	65	No education	Married
75	No education	Married	70	No education	Married
79	No education	Married	72	No education	Married
80	No education	Married	72	No education	Married

The elderly people were of the opinion that it was in the interest of the younger ones to seek advice from them from time to time. Moreover, they felt that the youth who failed

to consult them in matters of importance were proud and disrespectful. A male participant from Old Fadama said that:

"Yes, being the oldest or the elderly at home, if something happens, they will come and inform you. So, the elderly person will tell them or teach them what he knows and how to go about the issue. Yes if my son gets a woman he wants to marry, he will inform me and I will lead the delegation to ask for the hand of the woman in marriage for my son. In the event of a quarrel, the woman will come and inform me and I'll sit my son down and talk to him".

Another male participant from Fnateakwa stated that:

"One other very important role of the elderly in the family is that whenever there is an issue at the fore, the elderly person had to gather the other grown up members of the family to a meeting. The elder supervises the meeting and ensures that a consensus is reached. In this way, any decision taken by the group becomes biding on all the members".

It appears therefore that the familial role of the older population has not been obliterated with the passage of time. Changing social and economic circumstances do not seem to have eroded the traditional roles of the elderly at the family level.

Provision of Financial and other Assistance

The participants' views were mixed concerning their provision of financial and other assistance. On one hand, some felt that they were compelled by circumstances to take care of their grandchildren. On the other hand, others thought it was a cultural obligation to take care of younger relatives. One female participant from Old Fadama stated that:

"Look at my fingers, they are all not equal. Sometimes we assist them financially. Also, after suffering to bring up your child, in the future he/she is able to acquire some money to assist you financially, then, fair enough. But if unfortunately, your child is not able to take care of you, then one has to take it in good faith. Since may be, it is God who wants it that way".

Three male participants from Fanteakwa said that:

(i) "*We have already looked after our own children successfully, and if our grandchildren do not have people to look after them, we are obliged to see to their needs. Personally I have six grandchildren that I am taking care of. When their father died, there was no one to succeed him, hence I have to adopt them. Thus, just as I looked after my children so will I look after my grandchildren*".

(ii) "*I also have six grandchildren at my care because their fathers have shirked their responsibilities. I am a farmer and a painter so the little I earned from these ventures is saved towards the financial upkeep of the kids*".

(iii) "*Whatever I get, I make sure a little is saved for the upkeep of the kids. Even the last time school reopened, I managed so well to buy one of them all the books he needed. It is just hardworking and the sheer grace of God*".

Most of the FGD participants from the four study groups were not living with their adult children. Due to the death of their adult children or the migration of their adult children to cities and towns within and outside the country the elderly now contend with the double burden of fending for themselves and providing for the upkeep of their co-resident grandchildren.

Receipt of Financial and other Assistance

Many of the elderly people said that their grandchildren had grown and become adults and have therefore left home. But they tried to say how they related with them in their younger days. Their experience generally paralleled that of those who still had co-resident grandchildren. They stated that they provided financial and other assistance to their grandchildren irrespective of remittance availability or not from their migrant adult children. An elderly woman from Fanteakwa said:

"*My grandchildren are not with me now. They are now grown ups and I have trained them so they send me things every month. I was able to take care of my grandchildren from the age of two*".

Another woman from the same locality intimated that:

"*My grandchildren really appreciate what I have done for them so they tell me they will look after me till I die. One sends me money every month and clothes sometimes. If it hadn't been for them I would have been dead by now".*

Other participants from the other study locales expressed similar sentiments.

In general, it can be plausibly argued that the results support the contention that old people in parts of Ghana are confronted with the burden of fending for themselves and their co-resident grandchildren.

Self-reported Health Status

The participants were asked: What does being 'healthy' in old age mean to you? Various interesting responses were got as captured by the following answers.

"*It can be judged from the way one walks and conducts himself. Anyone who does exercises can be said to have good health. Thus, anyone who can walk for two miles is said to be having good health*". (An elderly man from Fanteakwa).

"*Another person though may be very old, may still be strong and be able to farm and walk for long distances. Such a person may be said to be healthy. I used to go to farm three times a day, now I go once every three months. Even with this I often fall sick when I come back from the farm. Somebody may be far older than me but may be able to sweep and farm. Another person may be able to carry foodstuffs from the farm to the house and even fetch water but I cannot do all these, which means that that person is healthier than I am*". (An elderly woman from Fanteakwa).

"*Being free from all from all forms of illness, diseases and sicknesses*". (An elderly woman from Old Fadama).

There was a unanimous agreement among all the FGD participants that their health had deteriorated.

An elderly woman from Old Fadama lamented that her health was "*Not very good. I for instance, all my joints ache to the extent that sometimes I cannot sleep well especially in the night*".

Her male counterpart from the same locality said that: "*There has been a change. Now if you sleep. In the morning it is difficult to wake up. You have bodily pains all over. When we were young, we work without becoming tired. We used to work from 6 am to 6 pm".*

Similar views were echoed from Fanteakwa. An elderly woman stated that "*I am not healthy because I am not able to farm; I have body pains all the time. I could go to the farm all the time but for a year now I have not been able to farm*".

An old man from the same area summarized the views of most of his colleagues when he said that: "*My health is deteriorating because I used to walk for 15 miles but I can't do that any longer. I even walk with the help of a stick".*

We wanted to find out whether the FGD participants assessed primary health care services in old age and if not why. Thus the following questions were posed: (i) In general, how important is it to seek health care in old age? (ii) How frequently? For what? (iii)

Where did you go the last time you felt ill? Why? (iv) What was your experience? The gist of their responses is captured in the following statements:

"*Comparing our state of health now to about ten years ago, we would say our present state of health is filled with diseases*". (Chorus response from old women of Fanteakwa).

"*Yes it is important to seek health care in old age especially since we are not able to work*" (Chorus response from old women of Fanteakwa).

"*Ideally, medical check up is expected to be done on a monthly basis. However, the more you go to the hospital, the more the nurses become fed up with you*". (An elderly man from Fanteakwa).

"*Frequent visits to the hospital make one become a nuisance to the health practitioners. They repeat the same medication that has proved inefficacious and they are hostile to the patient"*. (An elderly man from Fanteakwa).

"*In fact, most of us here use the health centers, it is only when we go back to our various hometowns that we depend on the herbs*". (An elderly woman from Old Fadama).

"Some of us don't go and will not go/visit the clinic/hospital. Among us the Dagombas, we use herbs. We have herbs that can instantly stop bleeding and seal a cut. In the olden days we did not have any foreign drugs but our herbs are very effective for headaches, stomach problems and all". (An elderly man from Old Fadama).

"*I used to go to the government hospital but anytime I go I am given paracetamol so I now go to a private hospital (Salvation Army). I went there the other time and the drugs I was given helped me. Because we are not charged at the government hospital, we are not given good drugs*". (An elderly woman from Fanteakwa).

"*The government hospital has not helped us so we now seek herbal treatment*". (An elderly woman from Fanteakwa).

It is clear from the foregoing that the elderly persons have not had a fair deal assessing primary health care in their localities. The government hospitals have not been fully patronized while herbal treatment is increasingly preferred due to a combination of cultural reasons and the hostile attitude of public health workers.

Impact of HIV/AIDS

Due to the exploratory nature of the study, it was not possible to sample many people. This has perhaps resulted in our small sample not capturing persons who were

directly affected by the HIV/AIDS virus. However, the views expressed hereunder are informative.

"*In the past, women were given in to men for marriage by their parents regardless of the age of their would-be husbands. Now, children of today do not depend on their parents and therefore go in for any man or woman they think is best for them. How dare an elderly person to choose a life partner for him/her? This has resulted in all these sexually transmitted diseases like HIV/AIDS*". (An elderly woman from Old Fadama).

"*We only pray that none of our children get infected with the disease especially as they travel to other places. We cannot say that the disease is non-existent. It is really a disease, which should not be taken for granted. Even the elderly can be infected if one does not remain faithful to the partner or if the husband decides to sleep with other women*". (An elderly woman from Fanteakwa).

"*In this community there is a high prevalence of HIV/AIDS. When the children are infected there is no hope for them how much more the elderly*". (An elderly woman from Fanteakwa).

"*It is only God who can help us. We don't know how the disease came so we only have to pray. I also pray that God will help us to get a cure for this disease. We also pray that God forgives our sins*". (An elderly woman from Fanteakwa).

The foregoing views are suggestive that the elderly persons were aware of the fatal nature of the AIDS and also knew of the principal mode of the transmission of the disease. But the discussions did not reveal that any of the participants, even from the area with high prevalence, Fanteakwa, had a personal experience to share. To what extent this was a deliberate attempt to hide it due to stigmatisation is not known.

Generation Gap (Changing Role of the Elderly)

Finally, participants were asked: "Looking over your own life from childhood till date, have you noticed any major shift in (a) the living arrangements of the household? (b) parents/children relationships? (c) position and authority of the elderly in the household? (d) position and authority of the elderly in the community?" Some of their responses are depicted below.

"*Yes there have been changes in the living arrangements of the household. Now no one eats in another man's house. The family has now been disintegrated unlike it was in the past. All*

of us here are related in one way or another by blood but we do not live as such now. Even when we often visit and given food, we are seen as beggars. The children will even call us names". (An elderly woman from Fanteakwa).

"*The cost of living has also increased unlike previously when we all used to eat together, today we only cater for our nuclear families alone. These days one cannot easily eat in another person's house due to financial difficulties***".** (An elderly woman from Fanteakwa).

"We lived together with our parents in the past but now each child builds his house elsewhere and decides to live there while we the elderly continue to live in the villages". (An elderly woman from Fanteakwa).

"*Some of our children have become disobedient. When they get something they do not show it to their parents or bring it to their fathers as before. This change is due to poverty and the financial difficulties that we face. Sometime ago, a child can not stand before the elderly person and insult the person"***.** (An elderly man from Old Fadama).

"Now, everything has changed. It is because our children work and earn money so they do not listen to our advice. This has resulted in their contracting of HIV/AIDS since some have become promiscuous". (An elderly woman from Old Fadama).

"*The changes that have occurred in the living arrangements of the household are as a result of civilization (modernization) and selfishness. Instead of working as a group, members now compete with each other in their bid to become prosperous. This has destroyed the love that initially existed among the members*". (An elderly man from Fanteakwa).

"*I see it differently in the sense that as a result of the latter-day modernization, children no longer stay with their parents for long and would rather want to settle permanently with their spouses, sometimes to the utter neglect of their siblings. This has had a very negative impact on the unity and strength that the family used to enjoy in the days gone by*". (An elderly man from Fanteakwa).

"*The position and authority of the elderly in the household have dimmed because what children were clearly not permitted to do in the earlier days, they now do them with impunity. This has come about as a result of the stubbornness on the part of today's children".* (An elderly man from Fanteakwa).

Thus the elderly persons themselves have noticed significant changes in living arrangements at family and household levels, as well as the position and authority of the elderly in the household and community. According to them, this was largely due to modernization and civilization. Increasing economic independence and separate living arrangements of their relatives seem to be eroding the traditional household and community roles of the elderly.

Such information as depicted in the foregoing discussion undoubtedly has important implications for the health and well-being of the elderly.

Discussion and Conclusion

None of the FGD participants seemed to have been directly affected by the HIV/AIDS pandemic although Fanteakwa is in the area with the highest prevalence of the disease in the country (Ghana Health Service, 2006[5]). The implication of the prevalence of HIV/AIDS is that there would be a noticeably fewer number of adults in the agriculturally productive ages due to the ravages of the HIV/AIDS pandemic. This is likely to undermine economic progress and pose enormous challenges to the government. The elderly persons, who are the grandmothers and grandfathers, are likely to be the most active persons to manage the agricultural and other family affairs in the event of the death of their adult children. A death in the household as a result of AIDS, for example, can have profound implications for agricultural resource allocation, production, consumption, savings, investment and the well-being of survivors This condition is likely to impoverish the elderly population.

It should be stated that in Ghana and many parts of Africa, the extended family usually plays the role of the social welfare systems that are found in the developed world. However, due to the rising levels of AIDS-related deaths in the face of increasing modernization and urbanization, leading to the rapid disintegration of the extended family system, orphanhood and the loss of traditional support mechanisms for the elderly will unquestionably become increasingly large problems. Therefore, the government of Ghana should provide agricultural assistance to the rural elderly poor in form of free inputs, special agricultural credits and grants. Also, because an overwhelming majority of Ghana's

[5] Eastern Region where Fanteakwa is located presents a prevalence level of 6.5 percent, considerably above the national average of 2.7 percent, with pregnant women in rural Agormanya, close to Fanteakwa, recorded at 18 percent in the mid-1990s (Health Studies Branch 1996).

elderly men and women reside in the rural areas, it is saying the obvious that their primary means of subsistence are agricultural activities, which by definition require much physical strength. With advancing age and concomitant frailty, these activities are likely to be deleterious to the health of the elderly persons. It is thus suggested that the government should institute alternative less tedious and viable income-generating programmes, such as handicraft and other physically less demanding activities that will provide means of livelihood for these rural elderly people, some of whom are widows and live alone.

The results of the analysis have shown that only an insignificant proportion of the elderly population had formal schooling. In fact, the 2000 Census of Ghana presents a dismal picture of educational attainment in the country as 43 percent of the population do not have any formal education and only 7 percent have post-secondary education (Ghana Statistical Service, 2002). Yet formal education is critical to the attainment of economic security in old age as societies respond to the modernization process. Since an overwhelming majority of the elderly persons, particularly women did not go beyond primary education, the government should encourage girls especially and boys to pursue higher education for their own good and that of the society.

It is gratifying to note that successive governments of Ghana have shown some concern for the aged. For instance, July 1, Ghana's Republic Day has also been declared as Senior Citizens Day, which is one way of responding positively to the concerns of the elderly and a clear indication of national commitment to the well-being of the aged. Similarly, the revised national population policy stipulates, inter alia, that "deliberate measures shall be taken to alleviate the special problems of the aged and persons with disabilities with regard to low incomes and unemployment" (Republic of Ghana, 1994: 39). Also, the newly launched National Health Insurance Scheme (NHIS) of the government of Ghana provision has been made for some exemption benefits for the aged that will take into

account their vulnerability and special circumstances (Daily Graphic, 2003). The scheme is expected to go a long way toward defraying the medical bills of the elderly sick. In the same vein, efforts to address issues impacting negatively on older people through a National Ageing Policy are underway. However, efforts should be made to attain this objective at the shortest possible time to alleviate the sufferings of the aged. Not all elderly persons have access to health services, especially in the rural areas. Currently, the cash-and-carry system (a user-fee scheme that entails full cost recovery for medical attention) affects all population subgroups (the elderly are exempt together with under-fives and pregnant women. However the policy is limited to only outpatient department (OPD) care. Also it is further limited by hostile attitudes of service providers, leading to a perception of poor quality care by the elderly). As a result of the economic situation in the country and its concomitant low standard of living and poor quality of life, the average elderly person finds it increasingly difficult to pay hospital bills. We suggest that the cut-off point for the qualification under the NHIS scheme for the aged should be reviewed to cover the elderly persons aged 60 years and over since that is the official retirement age in the country.

Furthermore, hostile attitude of some service providers in hospitals and clinics should be frowned upon and sanctioned where necessary to serve as a deterrent to others. It should not be forgotten that the elderly of today was the young productive adult of yesterday and therefore must be assisted in assisted in, not discouraged from, assessing primary health care since the ageing process exposes individuals to increasing risk of illness and disability. Indeed, physical health is for many elderly persons their single most important asset, bound up with their ability to work in the farms, to function independently and to maintain a reasonable standard of living. Everything should therefore be done to assist the elderly to remain healthy.

These policy implications need to be considered in the light of the study's limitations, however. In the first instance, the observed data used are cross-sectional; thus, implications about causality cannot be drawn. Additionally, the problems related to sampling errors should not be understated because the sample size was small and the approach purposive. Consequently, the findings might not be representative of the situation on the ground. Nevertheless, the study is illustrative of the condition and plight of the elderly population and is therefore important in that respect.

As the foregoing analysis is relatively new in the Ghanaian context, future research might build on the findings of this study. The influence of HIV/AIDS on the older population in terms of their coping strategies as primary caregivers should be further investigated for possible policy interventions. Furthermore, there is an inverse relationship between modernization and family support for the elderly, resulting in a growing incidence of low levels of well-being among the elderly persons. Yet, very little is known in Ghana about intergenerational transfers. In the traditional Ghanaian society, children are expected to support their parents in old age because there is no universal social security system. With increasing urbanization and modernization, it is vitally important to know something about intergenerational transfers from adult children (who live in towns, cities, and outside the country) to their rural elderly parents, and characterize the elderly persons' food security strategies in a fast-changing social and economic environment.

Food for thought: "*I believe we should pray for the government to help us. We don't have a peculiar work to do and if there is no child to take care of us then we our lives become meaningless*". (An elderly woman from Fanteakwa).

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