Does the Church Care? Assessment of Social Support Strategies on the Health and Wellbeing of Older Adults Within the Tema Metropolitan Assembly-Ghana

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Abstract

The aim of the present study is to identify effective and efficient social support strategies that could improve the health and wellbeing of older adults among religious organisations within the Tema Metropolitan Assembly (TMA) and transcend to other areas of Ghana. Thematic analysis was used as the qualitative methodology for this study where twenty (20) research participants were interviewed. Results revealed that the most dominant social support strategies adopted by the church are either instrumental or material, spiritual, emotional, and informational. Churches, Government, and other Social Service organisations must develop intervention strategies to promote general wellbeing among the older adult towards achieving the Sustainable Development Goals (SDG) 3 by 2030.

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What this paper adds:

1. This paper identifies how the church can contribute towards providing support to older adults.
2. Examines the critical role of social support on the health and well-being of older adults in religious settings.
3. Fills the gap and encourages more studies on how religious settings can promote the quality of life of older adults through sustainable social support strategies.

Applications of study findings:

1. The need for churches like those in Ghana to partner with government agencies and consider opening adult care homes, as done in countries like the U.S.
2. Non-governmental Organisations in Ghana and elsewhere should join the discussions to roll-out plans on how to effectively manage the aging adult. This can come in the form of centres of aging to educate people on how to provide care to improve quality of life among aging adults.
3. There should be collaboration between public and private organisations to invest in Technology assisted programs to improve the quality of life of older adults.

Introduction

The population of persons over aged 65 were estimated to rise by 55 million (8.5%) ratios over the recorded 8% (526 million out of 7 billion global population) in 2012 (Goodkind & Kowal, 2016). It is evident that aging has become a very critical area of study, especially to academics due to the worldwide growing trend and numbers recorded in this field. According to World

Health Organization (WHO) in 2014, it is estimated that over 2 billion people will be 60 years and above by 2050 with a life expectancy to rise to 75 years (AARP, 2007; Mba, 2010; Stanley & HAL, 2008; United Nations, 2009). According to Agyemang-Duah, Peprah, and Arthur-Holmes (2019), Africa recorded a 64.4 million people aging 65 and above in 2015 with the numbers fast increasing especially in developing countries (UN, 2015). Ghana's population as other developing countries is growing rapidly (GSS, 2013) due to the increase in life expectancy and a decline in fertility rates (Balcombe, 2001; GSS, 2013; Kwankye, 2013). These increased rates have led to increased dependence on the society accompanied with negative effects especially on their health and well-being (Channon & Falkingham, Van Der Wielen, 2018). Aging is the final phase in the transition of human beings with a need for continuous social support, social services, social security and welfare services for the growth and development of older adults (Ebimgbo, Atumah & Okoye, 2017). Therefore, aging should not be seen as an entirely negative process (Oladeji, 2011), rather an opportunity to provide them with all the support they need. The United Nations in 2002 proposed social support as a social dominance of active aging in developing countries. Aging is the persistent decline in the age-specific fitness components of an organism due to internal physiological deterioration (Rose, 1991). It is a life-long process from growing up and growing old which begins from conception to death (Chalise, 2019).

Aging in Ghana: Policy, health, and well-being

Majority of Older adults in Ghana are found in low earning employment such as farming, trading and craft work which has gradually increased their vulnerability as these activities require intense physical strength and commitment to time (Alidu, Dankyi, & Tsiboe-Darko, 2016). This then gives rise to

institute a policy framework to meet the needs of the older adult. In the past, the family system had provided social support roles (National Ageing Policy, 2010) to enhance the health and well-being of the older adult in what Apt (2000) notes as burden sharing. This projected in the saying "when your elders take care of you while you grow your teeth, you must in turn take care of them while they lose theirs" (Apt, 2000, p. 2). This is measured by how the person relates to others in a particular community as personhood in Africa is conceived as a communal one (Battle, 1997; Mbiti, 1969).

Due to the sudden breakdown of the family system especially in the 21st century, health and wellbeing of the older adult has been taken over by the state as well as other non-state institutions (including philanthropic and religious groups) with the family playing supplementary roles (Alidu, Dankyi, & Tsiboe-Darko, 2016). An Older adult according to the Ghana Statistical service (2012) is a category of adults who have attained advanced ages, 60 or 65 years. Also, an individual is said to be aging "…when he/she attains ages classified as old ages." In 2003, a national policy on aging was presented to Parliament for approval to address the issues associated with aging in Ghana. Fast track to 2010, the policy receives Parliament's approval as a working tool to transform and improve the lives of the older persons in the society (National Ageing Policy, 2010). With a vision to enhance the overall social, cultural, and economic reintegration of the older adult in society and improve on the quality of life of older persons in Ghana gave birth to this policy document.

The National Ageing Policy by the Government of Ghana has outlined eleven policies and strategies to improve the living standards of older persons in society and development. Peculiar to this study is to improve health, nutrition and well-being of older persons and to strengthen the family and community to

provide support to older persons. There are provisions in place to provide valuable support to the older adult. These include the Interstate Succession Law, 1985 (PNDC Law 11); the Disability Act, 2006 (Act 715); the Social Security Law, 1991 (PNDC Law 247) amongst others with specific provisions to enhance the welfare of the aged in specific ways (Alidu, Dankyi, & Tsiboe-Darko, 2016; National Ageing Policy, 2010).

Social support as a health & wellbeing strategy

Wellbeing is said to have strong relationship with health (Easthope & White, 2006) as widely used in available research literature. The focus has usually been on social support, social relations, relationships, social interactions, and friendship networks (Evans & Vallelly, 2007). Wellbeing presents more complex examinations of health and its related issues. It is about a person feeling good about themselves and functioning as well as their life experiences, norms, and social values; either subjective or objective (Office of National Statistics, 2013). Older adults have been faced with psychological problems; dementia, and depression which has been broadly accompanied by malnourishment and multimorbidity. Ghana just as other African countries have recorded high levels of communicable and non-communicable diseases (McCracken & Phillips, 2017a; 2017b; UN, 2014).

Social support is an indicator of the overall health and well-being among older adults. When the aged receive social support, they are more likely to have reduced health and wellbeing complications. When Older adults are deprived of the needed social support, it is detrimental to their general wellbeing which can cause intense unhappiness and stress (Pickett & Wilkinson, 2007). Providing physical support is said to increase

emotional wellbeing, which is relevant for older people and a characteristic of happiness. Encouraging social support for the aging population reduces social isolation and decreases mental distress such as depression among the aged. Social support has a positive influence on the health and wellbeing of older adult people (Chida & Steptoe, 2008; Dykstra, 2015) and this has been corroborated with extensive research that has focused on how social support impacts health and mental health (Mousavi, Kalyani, Karimi, Kokabi, & Piriaee, 2015; Reblin & Uchino, 2008; Seybold & Hill, 2001). To this extent, social support is the affirmative interactions that exist between two individuals to encourage people to stay or cope with their health adversaries and buffer their stress levels (Stangor, 2012; Thoits, 2011).

Social support and religion

It is now obvious that social support through established social relationships have influential effects on both the physical and mental wellbeing of people (Berkman, Thomas, Brissette, & Seeman 2000; House, Umberson, & Landis 1988; Smith & Christakis 2008). However, there is little attention paid to the role of religion in providing social support to the aging population. Despite this, extant literature on the subject matter has drawn a fine link between communities that are religious and the support they provide (Idler, 1987; Strawbridge, Cohen, Shema, & Kaplan, 1997). In extension, church-based social support has functioned as a stress-buffer as compared to secular social support (Merino, 2014).

Research has consistently established a positive relationship between religion and social support and health outcomes as 87% of the global population is affiliated with a religion (Gallup, 2011; Hill & Pargament, 2003; Lee & Newberg, 2005). Measures such

as positive wellbeing (Swinyard, Kau & Phua, 2001) and quality of life (WHOQOL-SRPB Group & Skevington, 2006) have been reported to be outcomes of religion and social support. Religion influences older adult's ability to cope with stress and increased health and wellbeing (Schmuck, 2000; Smith, Pargament, Brant & Oliver, 2000); less depression (Simoni & Ortiz, 2003) and reduced distress (Sowell, Moneyham, Hennessy, Guillory, Demi, & Seals, 2000). Religious social support expends coping strategies such as comfort, control, life transformation and meaning of life (Pargament, Koenig, & Perez, 2000). Consistently, the literature has indicated that those who attend religious activities regularly report larger social networks (Musick, Traphagan, Koenig, & Larson, 2000) than those who attend these activities less frequently (Bradley, 1995; Ellison & George, 1994; George, Ellison, & Larson, 2002). Extant literature has indicated some form of social support such as informational and instrumental religious support (Kanu, Baker, & Brownson, 2008), and emotional support (Krause, 2006).

Emotional and spiritual support is attained from religious audience, leaders and even directly from God (Krause, Ellison, Shaw, Marcum, & Boardman, 2001). Religious social support is usually fine-tuned to the kindness, tolerance and assistance exerted to the older adult to protect their overall wellbeing (Krause, 2008; Lundberg, 2010). Instrumental or material support comes in the form of shelter, clothing and food which is relevant to providing health and wellbeing among the aged. Informational support comes through advice given to the older adults on how to improve their wellbeing through physical activities such as exercises, eating healthy, and increasing social interactions with others.

Method

Research design

Qualitative, exploratory design with an interpretivist epistemology was adopted for this study to recount the subjective experiences of older adults within a specific setting (Blanche, Durheim, & Painter, 2006; Rahman, 2017). This design is considered appropriate for the study because it helps researchers to gain a holistic understanding of people's lived experiences within a specific setting. It affords the researcher with rich descriptive explanations to phenomena within a context and to discover rich experiences of a population and the meaning they attach to these experiences (Corbin & Strauss, 2008; Miles, Huberman, & Saldana, 2014).

Population, sampling technique and sample

The population for the study were older adult people and religious leaders from selected churches within the Tema Metropolitan Assembly in Greater Accra, Ghana. The number of older adult people aged 60 years and above within this geographical location under review stands at 7,306 (GSS, 2014). Christianity is the dominant religion in the Tema Metropolis making it the right population for the study (Ghana Statistical Service, 2011). The sampling technique deployed for the study was purposive (Alvi, 2016; Yin, 2011) with a prior purpose in mind and to gain rich information from respondent's experiences which is in-depth and insightful (Patton, 2015). The study sampled respondents from Pentecostal and Charismatic churches because they are the most notable religious sects in the Tema Metropolis making up 45.2% of the total religious sect in that district (GSS, 2014). The sample was made up of 20 participants (with at least one youth in any of the churches visited) and at least 1 presiding elder each from the churches that granted the interview.

Instrument

The main instrument for data collection was semi-structured interviews because the researchers wanted to investigate how people elicit their views in greater depth (Kvale, 2003). It contained a list of questions and was not more than 15 main questions (Boyce & Neale, 2006). The interview guide designed by the researchers were in two parts; A and B. Part A collected data on the demographic characteristics of the respondents. Part B focused on questions to examine the various social support strategies and how it improves the health and wellbeing of older adult people in the Tema Metropolitan Assembly.

Data collection

Written permissions were sent to the various Ministers in Charge of the various denominations within the Tema Metropolitan area. Discussions on the essence of the study were further established. Approvals were given by endorsing the permission letters for the interviews to commence. Each interview lasted about 20 - 30 minutes for two reasons; one, some denominations did not have any aging policy or had not heard about it and so answered fewer questions that were still relevant to the study. The lengthier ones have a lot to say about aging and the need to consider them in decision making even at the National Level of the church. Due to the emergence of the Coronavirus (COVID-19) pandemic, data collection took a longer period than anticipated. Research participants were duly informed, and their consents sought. The interviews lasted between October 2020 and May 2021. All interviews were recorded and transcribed before analysed.

Inclusion and exclusion criteria

Participants must be older adult members aged 60 and above and leaders who belonged to any of the Pentecostal and

Charismatic churches in the TMA were included in the study. The demographics of interviewees are presented in Table 1. Older adults who did not belong to the criteria above were excluded from the study. Young respondents were included in the study for purposes of future projection in aging. Finally, unwilling respondents were excluded from the study altogether.

Results and discussions

The first section of this section presented in Table 1 describes the demographic characteristics of the respondents. It comprises of various socio-economic statuses of older adults within the catchment area.

Religious social support strategies on health and wellbeing

This section of the paper focuses on the various social support strategies adopted by the church to ensure that the aged are managed and their health and wellbeing is improved. Religion has become an important part of people's lives (Philips, Chamberlain, & Goreczny, 2014) where churches are building an integrated force of bringing individuals together through various activities. These were captured from the themes that were developed from the responses given by the participants. These supports are reviewed quarterly by a team set up to assess its effectiveness and reach. They can make informed decisions and how to better manage the relationship between the church and the aged. As it is mandatory for most churches within this municipality to attend trainings on aging and refresher courses on counselling the aged, it is easier to manage this relationship. However, it is not without shortfalls as these can lead to damaged relationships as well as lead to excessive stress on the older adult

or in worse case, mental health damage or illness (Shoaib, Khan, & Khan, 2011).

Instrumental or material support

This form of support was the most ascribed to by all the respondents. For them, the church provides them with foodstuff, money in the form of token and end of year parties for the aged where the church through music engages them to dance and have fun. The leaders of the churches have confirmed that these are done as part of the church's plan to ensure that the aged are comfortable and happy in the church.

> *"The church visits us, bring us food, buy gifts, and bring money for us. Sometimes, they even visit us when we are admitted at the hospital."*
>
> *The church occasionally gives us allowances, present items such as food to us and during Christmas and citizens day, they organise parties and outings for us."*

The findings of the study are consistent with extant literature on how important material support is to the aged. Their health, quality of life and mental health especially are improved. During the pandemic, organisations or religious groups provided great support to the aged by providing food and other items to ease them of the mental burden of where to find food to eat to improve their physical health. These gestures have brought smiles on the faces of the aged because it reduces their anxiety and discomfort and increases their interest to continue to belong to the church.

Spiritual support

About 90% of the respondents reported that they receive spiritual support from the church. This has been through corporate prayers

for the aged and special prayer meetings for them. People and the aged alike would seek spiritual assistance from their pastors (Veroff, Kulka, & Douvan, 2001) than seek medical attention because their pastors are seen as spiritual and can provide this kind of support. A respondent opined:

> *"For me, when I don't feel too well, the first person I call is my pastor to pray for me. I have the believe that once I call him, I will be well."*

The social support provided by the church to the aged has been considered by extant literature as having a great influence on the health and wellbeing of the older adult in church settings than in non-church settings as reported by Krause (2006a). According to one minister in charge of a church, there has been a reformation in how church services are conducted for the older adult. These services have been tailored to ensure that the older adult enjoy hymns and songs they can relate to. They use this platform to pray for them. They visit them in their homes:

> *"…monthly to pray for us and to administer the eucharist."*

Emotional support

Since social support has the main aim of improving the health and wellbeing of the older adults through the establishment of social relationships, the emotional aspect cannot be overemphasized. Older adults have received emotional support from the church and other colleagues through the empathy and love they receive from these people. These supports unfortunately have not been what the respondents wanted yet they appreciate the little done for them. The new and old relationships they have built either satisfy or dissatisfy the social support process strategy that strengthens social cohesion. A respondent had this to say:

> *"…when they hear I am sick, they call me and some visit. During the visit, some give me money and I thank them. I always feel happy that somebody remembers me…."*

To some participants, this is absent in their churches and groups. Where it is present, it is insufficient. One respondent had this to say:

> *"I do not receive any support from the church or friends. Unless we meet and share and check up on each other nobody calls me or visits me. Although it's not frequent, I am happy when we do this. One time I was sick, but they never visited me…. I have no pleasure from the church as far as I am concerned."*

Another unhappy member who feels the actions of the church and groups to which he belongs have affected his emotional attachment to the church and therefore has negative implications on his health and wellbeing. He exclaimed:

> *"I don't remember the last time my Priest came to my house to pay a visit. Not even from any member. Not even from my own Men's Fellowship…I don't expect anything from the church but it's nice to check up on us. This makes us happy and to forget our problems."*

The discussions so far have centred more on the fact that most respondents are not happy with how the church treats them. This affects the emotional support they receive from the church and their colleagues at church. This is detrimental to their health and wellbeing. According to studies, emotional support as a social support strategy is in line with the contributions that the church can offer to the older adult (Ayete-Nyampong, 2008; Nantomah & Adoma, 2015). This has already been indicated as having a positive impact on the health and wellbeing of the older adult in society and especially those who belong to these churches.

Although this is expected by the aged, it is not fully maximised as analysed from the transcripts from the interviews.

Informational support

There is an increasingly strong correlation that exists between social support and improved mental health and wellbeing (Afroooz & Taghizadeh, 2014; Kamran & Ershadi, 2000; Pahlevanzadeh & Jarelahi, 2011). This can come in the information sharing or informational support. The older adult gets information about what is happening in their environment through the church as identified by Kruse (2008), Hayward and Kruse (2018), and Joseph and Linda (2017). These are usually through advice or health talks that expose the aging adult on how to adhere to preventive behaviours (Kodzi, Gyimah, Emina, & Ezeh, 2010) in the bid to live healthy and improve their health and wellbeing. A respondent intimated.

> *"The church organises health talks on aging, and they tell us what to eat and not to eat. So yes, they speak on diet issues concerned with aging."*

Another respondent who enjoys the informational support provided by the church had this to say.

> *"Every year, they organise retreats for us where we go and learn about how to live our lives as old people. They talk about the diseases we can get at our age and the food to eat…refrain from alcohol and abide by doctor's prescriptions."*

This form of social support provides messages that includes knowledge or facts usually given in the form of suggestions, advice, teaching, or feedback on actions. This provides an avenue for them to know what is going on around them making them feel less anxious and stressed. They are more balanced physically

and mentally. This was evident as 90% of the respondents interviewed belonged to groups or associations within the church that always provided information either on health tips or what is happening around the world.

Recommendations for practice

The issue of aging and social support, especially in the context of religion, is of great concern to people. As far as this discussion is concerned, the family continues to be the very primary source of support for the aged although in some contexts, this relationship has been weakened. Social support for the aging people among churches within the Tema Metropolitan Assembly has not been sufficient and consistent. This is because the support is either extended to the aged only on special occasions or in times of need when the aged is either sick or incapacitated. In anticipation of creating the right context to improve the wellbeing of the aged through various social support strategies, the following recommendations are made.

i. There should be collaboration between public and private organisations to invest in technology assisted programs to improve the quality of life of older adults.

ii. The need for churches to partner with government agencies and consider opening adult care homes, as done in countries like the U.S.

iii. Non-governmental organisations should join the discussions to roll-out plans in how to effectively manage the aging adult. This can come in the form of centres of aging to educate people on how to provide care to improve quality of life among aging adults.

Conclusions

This paper has demonstrated the various social support strategies the church has adopted in providing a conducive and appropriate environment for the aging adult to be physically, emotionally, psychologically, and informationally supported to improve their overall health and wellbeing. More specifically, the church provides material support in the form of provisions, cash donations and end of year parties; spiritual support in the form of prayer and administration of communion; information in the form of retreats, workshops and talks on how to improve their health and wellbeing and emotions through visitations and encouragement from their church leaders. This paper has identified that there are more avenues that can be explored to augment the support provided by religious organisations. However, it is prudent to indicate that there should be synchrony in this effort to eliminate gaps of interest and loss of focus. This paper has contributed significantly to the literature on aging and the role of the church in ensuring that aging adults receive the necessary social support they need to improve their health and wellbeing in Ghana.

Limitations and future research

The present study has limitations which directs prospects into future research. First, the emergence of the global pandemic, COVID-19 and strict restrictions limited the researchers to cover more aging adults within the church for fear of widespread of the virus. Second, the study did not allow the researchers to include charismatic churches within the geographical location under study. Future studies should explore these areas to provide a comprehensive view of social support and how this can improve the health and wellbeing of the aged in Ghana. Finally, the study

should be conducted elsewhere as the focus for this study was in Tema, which might show results different from what might be reported in other locations; different social, political, religious as well as economic factors. Therefore, generalizing the findings of this study needs to be carefully considered even though they are great insights towards the scientific development of social support and aging research in Ghana.

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