Exploring the Type of Social Support Available to Aged Male Hypertensive Clients in Ghana

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Abstract

This study sought to explore the social support available to aged hypertensive male clients in a municipality in Ghana. Data was collected from 186 selected men aged 60 years and older and diagnosed with hypertension for the previous 3 months. They were administered a self-developed questionnaire. The data was processed and analyzed using the SPSS version 23. Some of the variables were subjected to statistical tests and ranked in order of importance to respondents. Respondents accepted to participate in the study after giving their informed consent. It was evident that respondents do not get support to help take care of their conditions. Some of these few supports include feeding, health, and cleaning. Other assistance like clothing, socialization, medication, washing, transportation, and financial support were lacking. Based on the findings, the study concludes that improving support system for respondents, by the government, community, religious bodies, and family can optimize the care of aged hypertensive patients in the Ejura- Sekyedumase Municipality in Ghana.

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Introduction

Hypertension is a universal health problem which affects about 1 billion individuals worldwide and 7.1 million deaths annually (World Health Organisation (WHO), 2013). It is noted that hypertension is the leading risk factor for other diseases and the most important risk factor for cardiovascular disease (CVD) and other peripheral vascular diseases (Kjelden, 2018). Hypertension or High Blood Pressure is a single risk factor for stroke and constitutes 45% of the deaths in heart diseases (Shi et al., 2016), contributing to one-third of death globally in adults (Tibazarwa & Damasceno, 2014).

Prescribers in Ghana use certain ascribed indices of hypertension such as cholesterol level, body mass index and blood pressure to evaluate the effectiveness in the management of hypertension (Kjelden, 2018). Adherence to prescribed medical treatment plays a key role in sustaining the health and well-being of people. World Health Organization (WHO), believes that the degree of adherence of individuals are in several forms, these include taking medicines, adhering to dietary plan, lifestyle modifications which correlates with health improvement (Tibazarwa & Damasceno, 2014).

Social support for hypertensive patients is an area that is very important but has received very little attention in health promotion (Tovar et al., 2016). Social participation is a central component of the aged population health. Tovar et al. maintain that remaining active does not involve only physical, but being active in social, cultural, and psychological well-being. Social support comprise interaction with siblings, associates, age peers, and neighbors as well as networks that are created during working, entertainments, and other forms or through communal services (Adamczyk, 2016). There is evidence that social support

is critical for sustaining and improving health, functioning and longevity in our society (Pruchno, Heid & Wilson-Gunderson, 2018).

Aging is a story of change in individuals and families, a story of loss of physical and mental function, loss of family and friends and loss of spouse (Lloyd, 2016). All these implicitly or explicitly influence the health of the aged patients especially those with hypertension. McKenzie et al. (2018) posit that both women and men have strong social connections with their health, especially in their old age, indicating that there is quite different experience of aging for women than for men for different reasons. It is perceived that health at older ages develops or brings changes within a social context and within intimate partnership. From literature, there is evidence that social support of patients has a true connection in promoting one's health (Ivarsson et al., 2019). The aged are a heterogeneous group who are vulnerable to physical, mental, and social matter (Looman et al., 2018). This implies that aged health is related to several social problems.

The health and well-being of the aged, especially in hypertensive patients, depend on others. Research revealed that one of the essential elements for ensuring good health among the aged is social connectedness which promotes good social support (Santini et al., 2020). Studies have focused on treatment (Sheedko, et al., 2020) and prevention (Konlan et al., 2020; Rabi, 2020), however, little or none has been done on social support effect on hypertension treatment. In urban Ghana, older people may be systematically less likely than younger generation members to receive family resources to meet their needs (Colorafi, 2016). The Ghanaian literature document that the major factor linking poverty to old age is a normative hierarchy of generational priorities in the allocation of scarce resources. This hierarchy, which has crystallized in the overall context of economic

constraint, is perceived as legitimate and 'natural,' and gives clear priority to the needs of the young (self, spouse, and children), before those of older parents or relatives. The document added that the young represent 'future life,' and that the old have no 'right' to absorb resources needed by them. A second, additional factor indicated to limit the family resources made available to older parents is that adult children are increasingly making the extent of support to parents dependent on their judgement of the parents' past conduct and care and thus his or her 'deservedness.' Where children consider a parent to have been neglectful, they increasingly withhold some, sometimes all, support (Ghana Statistical Service, (GSS), 2002). Rural and urban Ghanaian evidence suggests that such 'retaliation' affects above all older fathers, i.e., men, often leaving them exposed to a dependence on charity (Colorafi, 2016). Older women, though not so much affected by retaliation, are, in the West as in other African regions, increasingly exposed to accusations of witchcraft, which limit the family support given to them (Gravetter & Forzano, 2016; Krejcie & Morgan, 1970). Again, on observation, when the aged visit the clinic for their reviews or for routine drugs, the males complain of poor care and neglect from their children and significant others, so the interest to use only male hypertensive patients in the study. The aim of this study is therefore, to explore the type of social support available to aged hypertensive male clients in a selected community in Ghana.

Method

Quantitative descriptive design was used for this study, a scientific method which involves observing and describing the behavior of a subject without influencing it in any way (Colorafi, 2016).

The selected community has a settlement population of 70,807 people and is the largest maize producing district. The people are predominantly farmers. The aged population in the selected municipality was estimated to be 8,365 (GSS, 2002). Inclusion criteria were all aged in the designated area with the age of 60 years and above as of December 2019. The sampling of 186 aged was agreed upon out of 8,365 based on Krejcie and Morgan sample size determination table with its appropriate confidence level and confidence interval.

The instrument for collecting data for the study was a close-ended type questionnaire. The questionnaire consisted of a list of question statements relating to the research question to be verified and answered, to which the respondents were required to answer by writing. The instrument used in collecting data for the study was divided into four sections on a four (4) point Likert Scale arranged according to agreement level (Strongly Agree, Agree, Disagree, and Strongly Disagree). Section A tackled the background information of the respondents while Section B measured items on the types of socio-economic support systems for the aged. Section C considered perceptions of the aged about the support systems available for the aged and Section D focused on ways by which social support systems can be improved for the aged. The item on the questionnaire was scored as Strongly Agree (SA) =4, Agree (A) =3, Strongly Disagree (SD) =2, and Disagree (D) =1.

To ensure the accuracy of the content and construct, the developed questionnaire was evaluated by experts in test and measurement for their inputs. The face validity of the instrument was also determined by the expert after construction to make sure it measures what it is supposed to measure. This was done according to the measure test subjectively (Ekoh et al., 2020).

Ten questionnaires were later piloted in a sub-district adjacent to the Municipality, to test its reliability and internal consistency. Cronbach alpha with a range of 0 to 1.00, where the mean value scored was 0.89.

An introductory letter was sought from the Department of Science Education, University of Cape Coast, Cape Coast explaining the reason for the research to the authorities in the Municipal assembly and the Ghana Health Service. The purpose and significance of the study was clearly explained to the participants and the various facility authorities. Participants were also made aware that their participation was voluntary and that they were free to withdraw their participation. The selected aged in the Municipality had the opportunity to fill in their questionnaires privately, to ensure confidentiality. In dissemination of results, measures were taken to ensure privacy, anonymity, and confidentiality of all participants by ensuring that the names of the participants were not used or revealed throughout the study. A letter of consent from the researchers to participate in the study was given to the aged as a courtesy of research to them and a means of ensuring their informed consent to participate in the study.

The questionnaire was administered to the aged at the institution whenever they came for review or for their medication without any undue influence. They were guided and given ample time to complete the questionnaire. Data collection done within three (3) months. All questionnaires were administered face-to-face, and some were collected on the spot.

Data were managed by coding, editing where appropriate, entering the data into the Statistical Package for the Social Sciences, version 23 to generate results and finally cleaning the data to remove any forms of outliers that may have gone

unnoticed. The descriptive nature of the research was made, and it was agreed that the researchers employ descriptive statistics (means and standard deviations) for analysis. The analysis was based on the 100% return rate of 186.

Results

Demographic Information of Respondents

Demographic variables for the respondents included their age and marital status.

Table 1: Percentage distribution of age and marital status of respondents

Variables	Frequency	Percentage (%)
Age/years		
60–65	67	36.1
66-70	59	31.7
71+	60	32.2
Marital Status		
Single	12	6.4
Married	124	66.7
Divorce/Separated	34	18.3
Widowed	16	8.6

Source: Field Data (2019) (n=186)

The finding showed that the majority (36.1%) of the respondents were within the 60–65-year group. Those from 66-70 year were the least with 31.7%. About marital status, majority (66.7%) of the aged hypertensive, male patients were married, with 6.4% being single.

Table 2: Descriptive Analysis of the types(s) of social support available for the respondents

Types(s) of Social Support	M Statistic	SD Std. Error	MR
Feeding	2.97	.278	1st
Health	2.87	.167	2nd
Cleaning	2.59	.868	3rd
Clothing	2.28	.379	4th
Socialization	2.27	.378	5th
Medication	2.13	.168	6th
Washing	2.17	.375	7th
Transportation	2.25	.437	8th
Financial	2.21	.179	9th
Mean of Means/SD	2.25	.381	

Source: Field Data (2019) (n=186)

Key-M= Mean, SD =Standard Deviation, MR=Means Ranking, n=Sample Size

To understand the mean scores, items/statements that scored a mean of **0.00 to 2.49** is regarded as item with low social support. Those items/statements that scored mean from 2.50 to 4.00 is regarded as high social support.

Table 2 presents results on the types(s) of social support available for the aged hypertensive male patients. The results give evidence that respondents do not get all social supports as needed. This was evident after the responses from the study where scores on average mean for some variables are (AM=2.25, SD=.381) more than the Test Value of 2.50. Some of these few supports were feeding support (M=3.97, SD=.278, n=186). Health

support (M=2.87, SD=.167, n=186) and cleaning support (M=2.59, SD=.868, n=186).

The following social supports were not available for respondents; clothing support (M=2.28, SD=.379, n=186), Socialization support (M=2.27, SD=.378, n=186), Medication (M=2.13, SD=.168, n=186), Washing support (M=2.17, SD=.375, n=186), Transportation Support (M=2.25, SD=.437, n=186) and Financial support (M=2.21, SD=.179, n=186).

The perceptions of social support by the respondents

Table 3: Percentage distribution on the perceptions of the provision of existing caregivers

Statements	Yes, F(%)	No, F(%)
Perception of whom to provide the need for respondents		
Self	33 (17.7)	135(82.3)
Children	168 (90.3)	18 (09.7)
Relation	121 (65.1)	65 (34.9)
Spouse	159 (85.5)	27 (14.5)
Friends	167 (89.9)	19 (10.1)
Government	130 (69.9)	56 (30.1)
Others	171(91.9)	15 (8.10)
Did you prepare for old age	58 (31.2)	128(68.8)
How does it feel to be your client's caregiver		
Dignified	12 (06.5)	174 (93.5)
Honored	33 (17.7)	153 (82.3)
Respected	15 (8.10	171(91.9)
Rejected	167(89.9)	20 (10.1)
Saddened	159 (85.5)	27 (14.5)
Dejected	169 (91.3)	17 (08.7)
Others	130 (69.9)	56 (30.1)

Source: Field Data (2019) (n=186)

As presented in Table 3, the results show that most aged hypertensive male patients perceived that their children (n=168, 90.3%), relations (n=121, 65.1%), Spouse (n=159, 85.5%), Friends (n=167, 89.9%) and the Government (n=130, 69.9%) should be responsible in providing them with their need social support.

The majority (68.8%) of respondents averred that they did not prepare for old age and further pointed out that they are not happy in their situation since most of them are rejected (89.9%), dejected (91.3%) and saddened (85.5%) based on their conditions. The results also give evidence to the idea that family members [children (90.3%) and relatives (65.1%)] are the major providers of informal support to the aged.

Discussion

Marital status is associated with health and survival outcomes among the aged. Separated aged experience poor health are not accorded respect and often stigmatized and marginalized on things that can benefit their health (Ekoh et al., 2020). This was explained by most respondents being married. The results also support the work of Shiba et al. who asserted that social support system is the informal social support system provided by families or households, friends, and other organizations such as religious groups (Shiba, Kondo & Kondo, 2016). This system varies among families and organizations and among countries. Family social support is the most popular informal support system especially in developing countries.

Similarly, the family provides love, affection, respect, security, and the sense of belongingness, which enhances the emotional well-being and promotes the self-esteem of the aged. The aged in turn also help busier younger relatives by attending to their children thereby showing that they are still useful and needed

by society. The majority (68.8%) of respondents averred that they did not prepare for old age, and this could explain why most of them needed assistance.

Family members are the major providers of informal support to the aged, especially daughters and daughters-in-laws. Older people receive financial and other support from adult children and that support is reciprocal (Evandrou, 2018; Ferrer, Brotman & Grenier, 2017; Aboh & Ncama; Peng et al., 2019). That in countries where there are well-established pension programs, many older adults give support and care to their children and grandchildren (Freeman et al., 2019). In areas where there are no well-established pension schemes and the aged never worked in formal jobs but invested in capital ventures and other long-term projects and offer support to their children and grandchildren.

Similarly, there is evidence that family support system is the provision of a befitting burial to the dead, especially death at old age, the last obligation of one's own children and relatives (Azeez & Salami, 2020). However, the greatest weakness of the family support system is that it is informal. Whereas most Ghanaians are willing to take care of their aged parents, young people often complain of their financial inability to care for their aged relatives as much as they would wish (Aboh & Ncama, 2019). The effect of modernization is the pressure on the nuclear family of younger wage earners to provide for themselves with little left for aged parents who may be at a distance (Forsberg & Timonen, 2018).

Ways that these support systems can be improved for the respondents.

The question of ways of improving these supports for respondents was received based on their health or condition. Some agencies that improve them with support, and it was recounted that most

of the respondents believed that the family and the community could play a significant role in improving the support systems. Others suggested that social welfare in collaboration with the government could play a significant role in improving the support for them. According to their responses, the government must institute measures to make provision for the aged. In finding out what could be done to make the family more effective in supporting the aged, the results show that education of the family could be beneficial. Respondents also believe that the family can be effective when NGOs and the government support them. Others shared a common view that programs should be organized in the community to expose the family to some level of knowledge on how to care for the aged for the family to be more effective in supporting their aged. The results alleged that the aged are offered informal support by non-governmental organizations. Religious organizations/bodies offer both social and spiritual support to the aged (Shiba, Kondo & Kondo, 2016). The document added that number of religious societies and groups have elaborate programs where they pay regular visits to the aged and people indisposed in their religious groups and provide seldom rationing in terms of food supply to the aged and destitute in their midst (e.g., St. Vincent de Paul and Legion of Mary societies in the Roman Catholic Church). They also offer regular prayers for the aged in their societies.

The main findings from the study showed that the respondents did not get basic support to help them take care of their conditions. For example, clothing support, socialization, medication, laundry, transportation, and finances were lacking.

Most of them perceived that their children, relatives, spouse, friends, and the government should be responsible in providing social support. Finally, it was revealed that in improving these

supports for the aged men, the government, the community, religious body, and family could help improve support systems.

Conclusions

The informal social support system is the main support system available to respondents. Again, the major responsibility of care for the aged has shifted from the extended family system to the nuclear family, where daughters, sons and daughter in-laws play leading roles. Also, there is inadequate social support for the aged especially about cash remittances and visits when aged are sick. The aged also realize that they cannot continue to always rely on their children for the needed support. This is also viewed within the context of the desire of the aged to continue working even at their retiring age and their demand for improvement of social support.

Strengths and weaknesses of the study

The findings of this study are limited is to the social support for male hypertensive patients in a farming environment. Since it was a quantitative method, the findings could be generalized to all patients who are male and hypertensive. Weakness is in the fact that the study was bias toward men.

With reference to the findings of this study, nursing implication could be that practitioners and community members need to acknowledge existence of the problem concerning the male hypertensive. There is the need to create awareness programs through outreach services in schools, churches, and use of mass media to these ignored social responsibilities. There should be better strategies between practitioners/caregivers and patients to give them understanding of the problem.

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Authors' contributions

JKZ conceived the study, was the principal investigator and made the most extensive contribution to the research. PW, IKA, and AEN were involved in the conception of the research, guided the development of the proposal. IKA and AEN revised the research and developed a manuscript for its intellectual and professional content.

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