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The Tale of Older Adults in a Ghanaian Urban Society During the Peak of COVID-19

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ABSTRACT

The study explored the psychological, social, and emotional challenges the older adult experienced during the peak of Covid-19. The interpretivist philosophy underpinned the study, utilizing phenomenological design to unearth the socio-emotional and psychological experiences of the older adults during the peak of the pandemic. Interviews were conducted to permit the participants to pour out their experiences during the period. The study unveiled that the older adults experienced social, emotional, and psychological challenges, which invariably had rippling effects on them. Social support was virtually non-existent for the older adults in the study area during the peak of the pandemic. The social bond and solidarity people used to offer their relatives including the elderly seemed to have been exterminated during the period. The neglect of the elderly during the period is a societal failure. Consequently, social, and behavioral sciences need to offer valuable insights for managing the pandemic and its impact on the elderly in society.

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Introduction

In late 2019, the world started experiencing one of the most dreaded and devastating health conditions and it escalated since then. The Coronavirus, alias Covid-19, was detected in Wuhan, China, in the late 2019 and it spread to all cranes and corners of the global world at a frightening rate. Covid-19 since then became a global pandemic having a toll on all aspects of the economies of the world and its people. In January 2020, the World Health Organization (WHO) declared Covid-19 a public health emergency of global pandemic following its sporadic spread to 118, 000 cases across the world after three months of its detection in Wuhan, China (WHO, 2020). The outbreak of the virus reached the rest of the world within a considerable short period of time (Radwan & Radwan, 2020b), which sent shivers and quivers into the spines of the rule and the ruled. By 26th May 2020, the dreaded disease had claimed well over 350, 000 lives and plagued 5.5 million human lives globally (WHO, 2020); and by end of the month of May 2020, the global infection rate had risen to 6, 000,000 with 400,000 deaths (Johns Hopkins University School of Medicine, 2020). At the national level, more than 7,000 Ghanaians had contracted the disease out of which more than thirty had succumbed to it (Ghana Health Service (GHS), 2020).

The indiscriminate spread of the deadly virus to every part of the world at an alarming rate had a toll on all categories of the world's population including older adults. Meanwhile, the world has been experiencing a rapidly ageing population. There had been a rise in longevity of people leading to the higher aged group. Worldwide, there were 1.2 billion older adults in 2010 and it was estimated to be 16% of the world's population in 2050 (WHO, 2011). Impliedly, during the Covid-19 era, the aged population was high. Coincidentally, it had been observed that outside crisis, the older adults have high rates of depression symptoms (Li, Zhang, Shao, Qi & Tian, 2014).

Research had also unveiled that the Covid-19 virus causes serious consequences to the elderly as there is a higher mortality rate in older adults and especially those with comorbidities like chronic respiratory disease, chronic kidney disease, cardio-vascular disease, and hypertension (Zainab, Ricci, Devyari, & Ramarao, 2020; Pant & Subedi, 2020). Consistent with this situation, Madhaven and Bikdeli (2020) had unearthed that patient with underlying conditions were mostly and severely affected by the Covid-19 pandemic. Armitage and Nellums (2020) had also discovered that older adults were the most impacted by the side effects of COVID-19. As NYC Health (2020) corroborated, the older adults formed a higher percentage of confirmed COVID-19 cases and mortality. WHO (2020a) further reported that older adults have a high risk of experiencing severe COVID-19 pandemic.

Age, therefore, is considered quintessential in reducing people's chances to survive the Covid-19 health condition especially those above 60 years (Jordan, Adab & Cheng, 2020; Zhou et al., 2020). The older adults' vulnerability to Covid-19 is due to the physiologic changes with ageing, which decreases the immune function of the human system (Sohrabi et al., 2020). The older adults having underlying health conditions facilitate acquisition of the virus or are predisposed to the condition. This situation renders older adults highly susceptible to contracting the Covid-19 virus and if they do, they have a higher risk of death (Petretto & Pili, 2020). Hence, the elderly constitutes the at-risk population.

The high percentage of the aged population and their vulnerability to the virus necessitated much more attention to their wellness. During the era of Covid-19 pandemic, all aspects of the wellbeing of the elderly including their social, emotional, psychological, and physical states ought to be of paramount importance to

all. As Fischer, Reriber, Baseher and Winter (2020) contend, the principle of solidarity, which is used in social health insurance scheme also applies to the Covid-19 pandemic. So, care givers, relatives, and friend's ought to act in solidarity and responsibly to protect the elderly who constitute the at-risk population.

Motivation for the study

The outbreak of the Covid-19 pandemic and its unimaginable consequences on the economies and the people of the world had ignited monumental research actions. Consequently, research attention has been paid to the effects of the pandemic on the citizens in general. Brodeur, Gray, Islam and Bhuryin (2020) studied the economic implications of the pandemic for Africa while Radwan, Radwan and Radwan (2021) investigated and discovered the main challenges facing older adults during the Covid-19 era to be preventive measures, misinformation, well-beings, limitation in access to nutritional needs and violence. Daoust (2020) examined older people's attitudes toward and compliance with the preventive measures of Covid-19 and uncovered that the older people in the study district had unfavorable attitude towards and poor compliance with the measures. Wong et al. (2020) also conducted a cohort study on the impact of Covid-19 on the older adults and found that it had significant increase in loneliness, anxiety, and insomnia. On their part, Pant and Sebdi (2020) investigated the consequences of social isolation on older adults and concluded that the practice had immense effects on their physical and mental health. A study executed by Blaser (2020) disclosed that feeling isolated leads to many deleterious consequences like anxiety and depression. Similarly, Cacroppo, Grippo and London (2015) discovered, among others, that loneliness was associated with risk factors including retrogression.

Although the foregoing studies sought to scientifically inquire into Covid-19 and the elderly, attention had not been focused on the psychological, social, and emotional experiences of the older adults who constitute the at-risk population in our societies during the peak of the disease. Research attention on the effects of Covid-19 and the older adults was essential because the restrictions and other protocols for curbing the pandemic tended to render the older adults isolated with their attendant difficulties. When the Covid-19 was declared a global pandemic, governments of countries around the world instituted public health preventive measures for their citizens in the bid to curtail the spread of the virus (Ultych & Fowler, 2020). The measures included social distancing, social isolation, and lockdown, which became necessary to reduce the risk of infection. Ordinarily, social isolation and loneliness had been linked to unfavorable mental and physical health issues such as increased anxiety symptoms and depression (National Academies of Science, Engineering and Medicine, 2020) and increase risk of hypertension, cardiovascular diseases, obesity, cognitive decline, and death (National Institute of Ageing, 2019). It had been observed that during the isolations, older adults did not receive visitors, which could increase their vulnerability and neglect (Gardner, States & Bogley, 2020) as well as make them susceptible to potential psychological stress (Makaroun et al., 2020).

Meanwhile it is during this period that close associates ought to offer requisite assistance, care, and support to the aged to ensure their safety via whatever means feasible. Morrow-Howell, Galuda and Swinford (2020) undertook an investigation and found that the Covid-19 had economic hardship and adverse health wellbeing effects and called for the need to increase family and intergenerational connections as well as renewed energy to combat social isolation. It was imperative then to conduct research into the untouched aspects of the aged and Covid-19 as

health includes not only the physical wellbeing of individuals, but also their mental and social affairs. The paper therefore sought to fill the lacuna by delving into the social, emotional, and psychological challenges the aged experienced during the peak of Covid-19 in an urban society in Ghana.

Method

The study was conducted in an urban Ghanaian society where care homes are not a common practice. In most Ghanaian societies, the elderly lives with relatives, mostly the extended family members including children, grandchildren and distant kins. At all times, the elderly relates and socializes with and enjoy social support from kits and kins. Not all the elderly receives support and comfort from members of their families, communities, religious affiliations, among others. This speaks to the close social tiers and bonds that prevail in the homes of the Ghanaian societies. Sunyani, the city where the study was conducted, is a cosmopolitan and a regional capital of the Bono region with diverse population about age and ethnicity. It was, therefore, an ideal environment to execute such a socio-cultural study to unearth how the social support, which prior to COVID-19, was a common practice, played out during the peak of the pandemic.

During the peak of the COVID-19 pandemic, Ghana, like most countries of the world, instituted measures such as social isolation, social distancing, and lockdown in the endemic centers although Sunyani did not experience lockdown, to curtail the spread of the virus. These measures invariably reduced movement of people, to a very large extent, although non-physical contacts were not disallowed.

The interpretivist philosophy underpinned the study, utilizing the phenomenological design to unearth the socio-emotional and psychological experiences of the older adults. The unstructured interview was conducted to permit the participants to pour out their experiences during the period. Rigor was ensured via the techniques of credibility, transferability, and confirmability. Re-reading and member check, audit trail and reflexivity were respectively employed to ensure credibility, transferability, and confirmability, and eventually led to enhancing the trustworthiness of the study outcomes. The analysis of the data followed the procedure given by Colaizzi (as cited in De Chesmay, 2014) which involves reading and re-reading of the transcript to have a feeling of their experiences, extracting significant statements to get the meanings, categorizing the meanings into clusters, integrating the findings into description of the phenomenon, validating the findings by returning to the participants and effecting any changes received into the final description of the phenomenon. The outcomes of the study were analyzed and presented thematically based on the issues which emerged from the conversations.

Results

The outcomes of the study are presented thematically based on the phenomena which emanated from the analysis.

Psychological challenges

Feeling worried and frustrated – the participants were always worried and frustrated especially on hearing of the death of the elderly in their vicinities.

> "*when I hear that some people have dead and were in their advanced age, then I become so worried. That whole day can't do anything for myself* (72 years, female)".

> "*as we were told that those of us who are old and have underlying conditions are susceptible to Covid-19, I never had my peace. I most of the time felt worried, I will suffer should I contract the virus"* (69 years, male).

Feeling distressed – the situation puts the participants in a distressed mood during the period.

> *"I was always feeling distressed which increased my sugar level almost every day"* (75 years, male).

Feeling rejected – the development prevented relatives and significant others from connecting with them.

> "*It was like, I don't have anybody in my life. No one will come to you and even your own kids will only come close when you request it. They all fear that old people get the disease"* (82 years, female).

> *"Do you know that your family members did not call to find out how, me the old lady was doing? Hmmmm, Covid-19, my family members, church members and community members I've been doing things with, rejected me" (69 years, male).*

Social challenges

Feeling isolated – the participants did not enjoy companionship with those they used to prior to the outbreak of COVID-19.

> *"I am always alone in my room. When you see me outside, then I need help and looking round to see if someone is there to help"* (66 years, male).

"I was always reading information from my phone and watching TV. I really wanted my grandchildren to stay away from me" (72 years, female).

Feeling helpless – the participants also felt helplessness.

"During the period, I was not able to witness and couldn't do one thing for a long. My concentration on issues was a problem" (80 years, female).

Emotional challenges

Feeling apprehensive – the participants felt frightened during the period.

"I was afraid that I will contract the virus, so, I was always thinking about it. I started when I heard that someone had contracted the virus at my hometown, I had visited less than a month ago" (70 years, female).

"My weak health condition always put me in a frenzy mood. They were saying that if you have some diseases, you can get it so easily. I was always afraid" (67 years, female).

Feeling moody – the condition made the participants moody.

"*Any small thing, then I become annoyed. At times, I was angry with myself for no reason and I used to realise that…"* (65 years, male).

"Not able to go out and having people to interact with was my headache. I then decided to avoid those who wanted to disturb me all together" (67 years, female).

Support from nuclear family

The participants enjoyed relatively good support from their close kins.

> "*My children did well by helping me with the things I needed. Even two of them who are not here visited and spoke with me that I'm safe*" (72 years, female).

> *"Oh, my children did well. They did all they could to help during the period while observing the protocols" (65 years, male).*

> *"My children who stay with helped although not too much…"* (80 years, female).

Support from extended family

The participants did not seem to have enjoyed support from their external family members during the pandemic. Their relatives did not, in any way, seek to check up on them to know how they were faring as older adults, who were vulnerable to the health condition.

> *"Hmmm, my relatives were not even calling. My younger brother I was expecting him to be calling to check up on me even did not believe the COVID-19 disease" (72 years, female).*

> "*I did not get support from my kinsfolks. Everybody was afraid of COVID-19, so they didn't visit to know how I'm doing*" (82 years, female).

Support from others

The participants averred that during the period they did not enjoy support from other significant categories of people such

as friends, religious affiliation members and members of their associations. Among other reasons for joining religious groups, associations and others is to enjoy social and emotional support during crises, yet the participants did not have the expectations fulfilled during the pandemic.

"Apart from my children, nobody came or called to find out how I was doing. Even my church members, it was recently that two of them met me in town and told me, they made the effort of reaching up to me but the calls didn't go through" (72 years, female).

"Hmmm, I called some of my former co-workers who are also old. I wanted to know whether they were safe" (65 years, male).

"I remember a priest and my group leader at church called me once to talk about church activities. Although they found out how I was faring, but I don't know whether they called purposely to know my welfare due to the Covid-19" (69 years, male).

Discussion

The stories shared by the elderly disclose that during the peak of the pandemic they experienced psychological, social, and emotional challenges which were worth the attention of those who matter in managing the affairs of the older adults. The psychological challenges that the older adults encountered were feelings of worry and frustration, feeling of distress and rejection. Hearing the news about the vulnerability of the aged and the unfortunate passing on of their counterparts who contracted the virus posed a psychological challenge to the older adults. The thoughts of them also are likely 'to give off the ghost' should they get the disease tended to wrangle in their minds which made them feel frustrated. This discovery corroborates that of Makaroun et al. (2020) that the pandemic made the participants

susceptible to potential psychological stress. The feeling of anxiety and distress served as a psychological challenge which is an unhealthy situation. Neuman, Mor and Kaplan (2020) also discovered that older adults experienced anxiety and depression due to the pandemic. This situation would make them feel a sense of uncertainty and fear. Studies had also discovered the psychological effects of the COVID-19 crisis to be stress, anxiety, and depression (Sigdel, 2020).

The emotional challenges that the participants had during the period include feeling of apprehensiveness and moodiness. According to them, they were uncertain of their faith as anything could happen to them. Consequently, they were always in a frenzy mood. The result confirms Pant and Subedi's (2020) discovery that the COVID-19 posed emotional challenges to the older adults. The pandemic caused emotional distress and feeling of loneliness to the elderly due to the lack of contact with significant people in their daily lives. The inadequate visitations by people, especially family members and friends, caused the older adults to feel sidelined which was a worry to them,

On the social challenges, it emerged that the older adults felt isolated and helpless. The social distancing and other restrictions required a reduction in movement. This development made the older adults stay alone in their residences. During the peak of the pandemic, they did not enjoy the companies of other people including their relatives which consequently made them feel isolated. The sense of fear and uncertainty was deduced from their stories. Kits and kins did not seem to have employed digital tools and other resources to get in touch, interact and fraternise with the older adults during the time they needed social support, the most. The inadequate support from the kits and kins during the peak of the pandemic as revealed by the study is consistent with what was discovered by Petretto and Pili (2020), which

made these authors to make a clarion call for the need to support the elderly during pandemics.

Pant and Subedi (2020) postulated that the COVID-19 measures such as physical distancing, movement restrictions and home quarantine contributed to the increase in social isolation especially for the elderly, a situation that the older adults in the Sunyani township experienced. The situation restricted the social lives they used to experience prior to the outbreak of the pandemic. Participants stressed the issue of isolation, and its associated challenges as human beings are gregarious animals who always desire to fraternise and interact with others, *ceteris peribus*. The participants felt rejected because of inadequate visitations. A study by Blaser (2020) disclosed that feeling of isolation leads to many deleterious consequences like anxiety and depression. Some studies had also unraveled that social isolation had negative effects on older adults (Shankar, Rafnesson & Steptoe, 2015, Windle & Woods, 2004), which are consistent with the findings of the present study.

The study further revealed that the elderly received little support from only close relatives, which was their only source of support. The stories shared by the elderly pointed out how they missed interactions with their cronies and longed to meet at church and with their associations' members. They really appreciated social interactions though they did not get it. It is based on this that Kiakowski and Nadolny (2020) implored those who matter in the lives of the elderly to offer more support for them in challenging times. There is the need to create chances for older adults to have social contacts via non-physical means such as virtual conversations. National Academies of Science (2020) had called for the institution of programs that can escalate social connections between people to reduce the negative repercussion of social isolation. Affo (2020) also contends that virtual socialising and

online events are a common practice which helps to keep people from being completely isolated. Sequel to this idea, Finn (2020) suggests that people could be connected online during and after social distancing protocols are no longer in place. Digital tools and resources might be used to reduce the social isolation older adults experience and to help them stay in touch with family members and friends (Radwan & Radwan, 2020b). Technology is the sure bet for people including older adults to stay socially connected (Friemel, 2016). It flows from these expositions that COVID-19 should therefore teach us diverse ways we can connect to people non-physically to offer social and other supports to others, when needed. Social support is required by all, but most critically, the older adults during pandemics.

Conclusion

The challenges that older adults encountered during pandemics are overwhelming and warrant the attention of various relevant professionals. The complex health, social and psychological conditions of the older adults require multifaceted inquiry for a thorough understanding. This underscores the innumerable scientific inquiries that have been made about the older adults in the era of COVID-19. The present study adds to the plethora of studies on phenomena. The study's outcomes portray that the elderly experienced psychological, social, and emotional challenges during the peak of the pandemic in the middle and late 2020, which invariably had rippling effects on them. The study outcomes insinuate a woefully inadequate, and in instances, non-existent social support for the aged during pandemics. The social bond and solidarity that prevailed in the various Ghanaian societies seemed to have reduced or exterminated during the period. The profound expression of inadequate support via whatever means possible is a societal failure, which the social and

behavioral sciences need to offer valuable insights for managing pandemics and their repercussions on the elderly in society. The need for significant others to improve society to benefit the aged and their relatives cannot be overstressed.

It is believed that since ageing and COVID-19 are not unique to the study area, but to all societies, strategies from other societies to promote the health of the aged in the study area could be adopted. It is an imperative need for authorities to promote the health and wellbeing of the aged by fashioning out appropriate social policies targeting the at-risk population. We also need to promote healthy ageing in our families and communities for the benefit of all. The admonition by Morrow-Howell and Swinford (2020) that we need to increase family and intergenerational connections as well as renewed energy to combat social isolation that the older adults experience ought to be embraced by all for the welfare of the older adults during such unfortunate periods.

Limitations

The study has revealed the stories of the elderly on the socio-emotional and psychological challenges encountered during COVID-19 in an urban center in Ghana, which adds to the burgeoning literature on COVID-19 and the elderly. The study also contributes to understanding the state of the elderly during pandemics and how we can improve the social support we provide for the at-risk populations.

Despite the contributions of the study however, there are limitations such as the following, which ought to be recognised when reading the work. Primarily, the study adopted only a qualitative approach with its limitations of small sample size which provides just a small picture of the phenomena studied. The study utilising only the elderly in providing data about the

phenomena studied without the inputs of close kits and kins also limits the scope of the study and denies us of vital facts to crosscheck or triangulate.

Based on the identified limitations, it is suggested that a more elaborate study should be conducted to embrace both the elderly and their kits and kins to engender triangulation and broaden the scope of the study. Besides, as the study was conducted in an urban city, its replication in the peri-urban and rural communities to ascertain the socio-cultural and psychological challenges the elderly encountered and the support they received during the peak of the COVID-19 pandemic would not be out of place. Further, a comparative study of the challenges the male and female older adults experienced and how differently or otherwise they were supported by kits and kins would be laudable.

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The Impact of COVID -19 on Family Relations: Implication for Ageing

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Abstract

The COVID -19 pandemic continues to affect the well-being of individuals and societies. Its associated lockdown and social distancing measures have further impacted family relations by distancing individuals from family and social networks. Using the symbolic interactionism theory as a framework, this study aimed to find out the effects of COVID -19 on family interactions (relationships). Thirty students from the University of Ghana were purposively selected for the study. Participants were asked to write about their experiences during the pandemic and its effects on family relations. Data were collected over a period of fourteen days. Thematic analysis was employed in generating themes based on the responses. Respondents reported both negative and positive effects. Reports on the negative effects included *fear of contracting the virus* (hence distancing themselves from family members), nose mask wearing which *hampered communication* (hence their messages being misunderstood and misinterpreted) and *inability to visit and relate with extended family members*. On the positive effects, it brought the nuclear family together and improved interactions among them. Implication for ageing in the COVID -19 era and beyond is discussed with reference to the family as an institution.

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Introduction

The COVID-19 pandemic has had significant implications for the physical health, mental well-being and education of individuals, families, and communities. The effects of the pandemic have been far reaching, overwhelming health systems, causing economic losses, and disrupting the way of life of millions in COVID-19 hotspots around the world. People from all social classes including the rich, poor, aged, children, women, men, disabled and the vulnerable in society have had their normal way of life curtailed. Many countries-imposed lockdowns at various times to prevent the spread of the virus as well as limit deaths. On the 13th of March 2020, Ghana's Ministry of Health confirmed the first two cases of COVID-19 in the country. On 29th March, Ghanaian authorities announced a lockdown in Greater Accra, Kumasi and other localities which were deemed to be harbouring probable cases of COVID–19 to allow enhanced case detection and contact tracing of the cases. This lockdown was enforced by security personnel and was accompanied with public health authorities sometimes going house to house to trace COVID-19 cases and their contacts. These social restrictions and additional public health measures increased public anxiety. Self-isolation (not leaving the house even for shopping), depression and anxiety have been documented among older persons during the lockdown (Brown et al., 2020). There were positive experiences reported with less than 5% of the participants expressing being lonely most of the time. Studies on the impact of COVID have shown both negative and positive experiences (Brown et al., 2020; Kalil et al., 2020; Tener et al., 2021). It was projected that increased incidents of poor health (UNICEF, 2021) and food insecurity (FAO & WFP, 2020) resulting from the pandemic will intensify socioeconomic inequalities in life course outcome (Asante & Mills, 2020; Roxana, 2013).

Defining the family

Defining the Family

Family is the building block of every society (Preda et.al, 2020). It is not restricted to people living in one household at a time (Sharma, 2013) nor limited to blood ties (Yamaura, 2015), residential arrangements and legal status of a group of people (Tam et al., 2017). Functions of a family is derived from its definition. Families are expected to provide economic support, inherited social status, education, protection and care of the sick, religious training, leisure time and entertainment, emotional support, socialisation (Gibson & Gibson, 2020). Gerson and Torres (2015) like other family scientists posit that 'all societies have families, but their form varies greatly across time and space'. They argue that changing family forms have been because of:

> *'the interplay of shifting social and economic conditions, diverse and contested ideals, and the attempts of ordinary people to build their lives amid the constraints of their particular time and place'* (Gerson & Torres, 2015, p.1).

Gerson and Torres' (2015) definition lend support to the family being defined by its functions and types. Family sizes have become smaller as a result of education on family planning methods (Hazan & Zoabi, 2015). More 'single parent' families are common in recent times (Nieuwenhuis & Maldonado, 2018). Single parent families are households containing only one parent, usually a woman and one or more children as a result case of divorces, death, and other unpreventable factors. It is increasingly common to find unmarried couples living together, and unmarried women having children in cohabitating relationships. Another form is the blended families composed of a man and a woman and one or both their children from previous marriages. Hence, living with children who are not

their biological children as in step families (Portrie & Hill, 2005). Blended families can also be called reconstituted families. Finally, there are adult males or females living alone as a choice, a form known as alternative families (Scanzoni, 2001). This can be distinguished from the normal traditional families where a family is a group of people and not a single person.

Nuclear and extended family

There are two types of family; the nuclear and extended family (Sharma, 2013). The nuclear family comprises of the father, mother, and children while the extended family is an amalgamation of different nuclear families within a lineage. The extended family in Ghana consists of grandparents, uncles, aunts, nephews, nieces and cousins; people who transmit values, firmly rooted in the Ghanaian society (Dzramedo, Amoako & Amos, 2018; Mawusi, 2018). Family promotes a sense of community; therefore, efforts should be geared towards maintaining the sacred family bond and traditions held dear especially among extended family relations (Amoako & Mawusi, 2018). Members of the extended family provide care and loving support to the ill and unfortunate within the family system. This confirms that the family helps strengthen, sustain and revitalize individuals with the capacity to do their best in every sphere; contributing to societal, national and global development (Tanga, 2013). Regular interactions with family members make people feel like they belong; like they matter, while feeling a sense of responsibility, security and commitment towards all things they hold dear; their personal, economic and social lives (Jansen, 2017). Grandparents are important in shaping and assisting all matters relating to the progression and direction of family members (Stewart, 2007). The nuclear family is crucial in nurturing children and a simple, basic and elementary component of society (Chudhuri, 2011)

Family gives a group of people an identity and a shared history (Koerner & Fitzpatrick, 2002).

Some Ghanaians belong to nuclear families, in which only two successive generations-parents and their children-share a household. But some households extend the family to include grandparents, uncles, and cousins as well. They are called extended families (Dzramedo et al., 2018; Stewart, 2007) often with three generations living in one household.

Family life cycle and dynamics

Family life course development is the undulating pattern of events, observable or expected within the family (Falicov, 2016; Ha, 2014). The modern family is characterised by an average period of about 40 to 45 years of married life and goes through three broad cycles: beginning, expanding, and contracting stage. In the beginning stage of the family cycle, young couples learn the art of homemaking and lasts for at least a year. The expanding period has two phases. The first represents periods when the babies arrive and family size increases from 2 persons to 3 or more. This stage is filled with physical care and supervision, loving and protecting babies and guiding older children (Kapinus & Johnson, 2003). The second phase of this expanding period known as the peak years ends at about the 25th year of marriage life when the youngest child reaches about 18 years of age. These years (when the children are in school) present their own unique problems in the family's monetary management just as the early years did. Teenage males and females begin making demands on the family income, on the time of other family members and on material possessions (Lubenko & Sebre, 2010). Even though family incomes increase, this happens to be the time of greatest expenses for the family. As adult children leave for school and

career, parents are left alone, thus the contracting stage. Problems related to the use of time arise; as the husband retires from his work, the wife also finds that responsibilities to her children no longer demanded her time and energy (Mitchell & Lovegreen, 2009). The emptiness that characterizes the departure of grown children and retirement from a job are hard to face unless the parents have kept up interests outside the family and the husband's occupation through the expanding period of family life. The financial problems and boredom that characterize this later stage can be daunting for the ageing in families.

Ageing encompasses the apparent deterioration in an individual in the course of his or her life (Kirkwood, 2005) the collapse of bodily systems and impaired ability to survive in a fast-changing world (Candore et al., 2010; Vasto et al., 2010). Ageing is considered to be successful not in the absence of disease and disability, but when the members of the ageing population are able to carry out activities autonomously while maintaining strong family relationships and living in a harmonious environment (Nosraty et al., 2015). A strong social network (social bonding and a cohesive environment) and as revealed by Ding et al. (2020) is invaluable in ensuring successful ageing in older adults. Örgütü (2020) highlights key considerations for healthy ageing i.e., diversity and inequity. For aging diversity it is argued that a typical ageing person may not be found because 'some aged people may still maintain their mental agility, others may require care and support in achieving 'basic activities like dressing and eating.' To this end they recommend that policies be framed 'to improve the functional ability of all older people, whether they are robust, care dependent or in between.' In terms of inequity Örgütü (2020), recognises that,

> *A large proportion (approximately 75%) of the diversity in capacity and circumstance observed in older age is the result of the cumulative impact of advantage and disadvantage across*

> *people's lives… the relationships we have with our environments are shaped by factors such as the family we were born into, our sex, ethnicity, level of education and financial resources* (Örgütü, 2020).

Communication

Human interaction cannot exist without communication. Communications is defined as the process of sharing ideas, thoughts, and feelings among people. Information is usually transferred from a source (a person) to a receiver (another person) through a channel or medium (verbal, phone call or chats) which results in a feedback (Wornyo et al., 2021). Communication primarily involves making meaning out of symbols in a way that is accepted and widely recognized by a group of people (Koerner & Fitzpatrick, 2002). Humans are social beings and often see themselves as belonging to groups of families and societies. As such, they consider it natural to show kindness, share material possessions with family members and thereby become distressed when physically alienated from close relations (Sauber, L'Abate, Weeks & Buchanan, 2014). Frequent communication is crucial in maintaining healthy family life, proper socialisation and is a sure means of resolving conflict (Koerner & Fitzpatrick, 2002). People view communication as an indispensable skill, essential in facilitating their quest for better lives (Tili & Barker, 2015).

Theoretical perspective: Symbolic interactionism

Symbolic interactionism (SI) coined by Herbert Blumer (Forte, 2010) states that humans behave differently based on the value they ascribe to things and the observable social context for an occurrence. Interactionists believe humans thrive in a symbolic environment (Forte, 2004) and that interactionism stems from

the notion that social contexts indisputably exude variant interpretations of an event (Forte, 2010). Symbolic interactionists seek 'to investigate collective social meaning from the ground up' (Del Casino & Thien, 2020) suggesting that societal meanings are constructed and reconstructed through practice. Symbolic Interactionism favours individuals over societies but

> *the intent is actually to consider the individual and society as mutually constitutive: all social action is interactive between individuals and thus it must be thought of as complexly intertwined with and productive of collective meaning* (Del Casino & Thien, 2020, p. 177).

Aksan (2009) corroborates that to understand human behaviours,

> *it is necessary to understand definitions, meaning and processes formed by humans first. Elements such as social roles, traditional structures, rules, laws, purposes, provide raw material to the individuals for forming definitions. In this context, symbolic interaction stresses social interaction, debate of definitions and taking emphatic role between people (*Aksan et al., 2009, p. 904).

Briefly, symbolic interaction is interested in the meanings individuals ascribe to events. Hence requiring a realist approach to inquiry. The event in the context of this study is the COVID-19 pandemic. Interactionists are concerned with people's perceptions and how their perspectives for interpretation affect quality of life (Forte, 2004). This study therefore sought to understand the lived experiences of participants' family relations in the wake of the COVID-19 pandemic. COVID-19 brought in its wake a lockdown (partial or total) and social distancing. Families were made to stay at home. It was sudden, unexpected, and left little time to plan for the long-term. How did families cope during this time? The study aimed at finding out how the incidence of COVID-19 affected the family interactions (relationships) of participants.

Symbolic Interaction methodology

Symbolic Interaction's goal is understanding the nature of the social world. To maintain the phenomenon under investigation, researchers should adapt 'a real world' methodology with flexible data collection strategies (Fontana, 2015). The argument here is that methods should be ever changing to fit the changes and events of the real world (Fontana, 2015).

Method

This study was conducted on the main campus of University of Ghana, Legon, located in the Ayawaso West Constituency in the Greater Accra Region of Ghana**.** It was the chosen site because of its cosmopolitan nature. It has students from all social classes and ethnic backgrounds.

Participants

The target population for the study was undergraduate students. Thirty (30) University of Ghana students were purposively selected for the study. The sample was based on students who had extended family relations and were available and willing to elaborate on how the COVID-19 pandemic affected their quality of life. Informed consent of participants were sought and participation was completely voluntary (WHO, 2020).

Instrument

Data was collected using a semi-structured interview guide with an open-ended question which elicited variant personal responses.

Data Collection

Whenever a respondent gave their consent to take part of the study, each was taken through the objectives of the study and guaranteed confidentiality. Interested and available respondents were interviewed on their experiences during COVID-19 and its effect on familial relations. They were made to write out their experiences on paper, an approach 'more highly focused and reflective...facilitating data analysis and interpretation'(Handy & Ross, 2005, p. 40). COVID-19 protocol of ensuring social distancing was strictly enforced. Within a span of fourteen days, researchers retrieved and transcribed responses into a word document. Following ethical principles of WHO (2020) each transcript was assigned an alphameric (e.g., respondent 1 to respondent 30).

Analysis

Thematic analysis was the chosen method for analysis due to its flexibility (Braun & Clarke, 2006; Nowell et al., 2017). The checklist for analysing qualitative data as outlined by Braun and Clarke, (2006) and revised in Xu and Zammit (2020) was employed. Researchers familiarized themselves with data, 2. Generated initial codes, 3. Searched for themes, 4. Reviewed themes, 5. Defined and named themes, before finally 6. producing the report (Xu & Zammit, 2020). To this end, responses were read, re-read and initial codes generated, additional reading of transcripts to select themes that evolved were done. Researchers verified 'themes against each other and the original data set' (Braun & Clarke, 2006, p. 96). To ensure rigor in the analysis, this back-and-forth activity dealt with searching, reviewing, defining (redefining) and naming of themes. Themes were then checked for clarity and unambiguity and 'distinctiveness' (Braun & Clarke, 2006, p.

96). Relevant recurring themes were then grouped into *positive* and *negative* themes. These themes, discussed below, informed researchers on how the meaning, relationship and relevance of information obtained captured participants experiences on the effect of COVID 19 on their family relations.

Results

Demographic information

The study recorded more females (26) than males (4) participating in the study. They were between the ages of 19 and 24 which indicates that they were all in their youthful years as is expected in most tertiary institutions.

Themes from the study

The themes that evolved included both positive and negative outcomes. Reports on the negative effects included *fear of contracting the virus*, *hampered communication* and *inability to visit and relate with extended family members*. The positive effect was that it brought the nuclear family together and improved interactions among them.

Fear of contracting the virus

Five (**5**) of the thirty respondents stated fear of contracting the virus as a determinant of self-consciousness, heightened eagerness to self-isolate and attempts to avoid people formerly allowed to invade their personal space.

Respondent 1 said, "I *thought all hope was lost, I had different thoughts going through my head; 'am I going to die' 'what happens if I contract the virus*". Jopp et al. (2015) threw more light on the

role vibrant social environments play in unproblematic lifelong ageing; how family alienation propels premature ageing. Fear of contracting the COVID-19 virus causes a tear in family bonds, a loss of trust and avoidance behaviour in the family, consequently affecting well-being. Based on three (3) respondents, the stigma associated with family members who test positive for COVID-19 makes family members trust themselves less and have less fruitful conversations. Respondent 8 elaborated, "*While my aunt battled with COVID-19, she was never spoken to, not even on the phone. Nobody was willing to engage her in any conversation and so she couldn't experience the love and affection. She felt neglected.*"

Hampered communication

Ineffective communication due to obstructed body language signals

Three (**3**) respondents said communication with family was ineffective owing to verbal and body language signals not being observed through the phone. Respondent 10 stated, "W*e lost things that made us feel good or helped us understand a message better since non-verbal cues were not applicable through phone calls".* Nine (9) respondents indicated that the messages were unclear and likely to be misinterpreted because nose masks muffled the words sent across. Respondent 19 highlighted: "*face mask in particular muffles sound and hides facial expressions during face-to-face communication... If it had not been for the pandemic, messages would be clearer right away".* Family interactions are rendered unfruitful in the absence of meaningful cues and conducts, leading to a deterioration in family relationships (Brown et al., 2020)

Inability to visit and communicate with extended family members

Seventeen (17) respondents stressed on the issue of not being able to visit their extended family members as the cause of rift in relationships. Respondent 17 said, '*during this stressful period, our extended family members cut ties with us. They were reluctant to visit us. Therefore, non-verbal communication with them ceased too."* This person lost contact with the people he needed the most in a debilitating circumstance. Three (3) respondents said they were not able to communicate with family because their grandparents lacked mobile phones and the knowledge to operate them. People end up being lonely especially when all efforts to reconnect with family have proved futile. An assertion that was corroborated by Ayalon and Avidor (2021). A lack of dexterity in mobile phone operation is a cause of worry for many grandparents, according to respondents. Doraiswamy et al., (2020) implores society to be empathetic towards the ageing population as most of them may not be technologically inclined.

Fifteen (15) respondents grieved that the relationship and frequency of communication with extended family members became costly owing to the need to purchase large internet bundles to ensure consistent contact online. To lessen such a burden, de Biase et al. (2020) recommends a multidisciplinary approach to rehabilitating affected individuals. Seven (7) of the respondents aired the concern that poor network caused problems as far as effective communication with loved ones was concerned.

Respondent 6 recounted, "*Sometimes, there are network problems due to the weather. Other times, the credit gets finished.* These issues make communication not as effective as they used to be before the pandemic, exacerbating the effect solitude has on ageing and well-being.

Conflict resolution and strengthening of nuclear family bonds

With regards to the positive impact of COVID on the traditional Ghanaian family system, nine respondents said they were able to maintain communication with extended family members by using social media applications such as Zoom, Skype, WhatsApp, and Microsoft Teams. Respondent 27 said, "*We expressed our concerns, resolved some unsettled issues and also enjoyed quality family time*". More than half (19) of respondents said family members were able to resolve conflict, reconnect and spend time with each other which strengthened the family bond. Brown et al. (2020) found an increase in the 'sense of community' and social connectedness with neighbours as a positive aspect of COVID-19 because the pressure of 'having to go out' had been taken away. Respondent 23 agrees that "*the pandemic led to so many crises but strengthened communication among family members; we always had morning devotion together, washed and ate together*" Four respondents said the situations surrounding COVID-19 propelled them towards developing their communication skills and aptitude at using social media.

Discussion and conclusion

Ageing runs across the lifespan and requires certain factors to progress smoothly; one of which is a substantial social environment within which one feels loved, appreciated and able to communicate thoughts and experiences freely. In today's world, the individualistic culture has set apart families and destroyed the extended family relations in the Ghanaian culture. This has made it difficult to meet as a family and share long-held traditions. In the advent of the COVID-19 pandemic and the need for social distancing people stood far from each other when

having conversations, were not as eager to visit or allow visitors as before and had less inclination to stay connected with others. In a setting or environment, people prioritize the things they care about and perceive things in whichever way they deem fit. In effect, they associate the detached nature of their closest family members as a sign of little interest in them, which hurts their pride; they just want to be loved and appreciated. According to the respondents in this study, little time was spent with family outside of their immediate environments, especially because they feared contracting the virus which made them unwilling to be too close to family even in moments when they end up being together. COVID-19 has ingrained in us a fear so immeasurable that some people now have almost no social contact. The aged are at risk of being socially alienated and requires that family and or community reintegration efforts are deliberately undertaken. In this life, we need people to survive.

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COVID-19 Pandemic Vaccine Uptake, Hesitancy, and Myths: The Worldview of Older Ghanaian Adults

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Abstract

The study sought to investigate COVID-19 vaccine acceptance, uptake and hesitancy including the myth(s) militating against COVID-19 vaccine uptake among older Ghanaian people. There is the need to ascertain the emergent COVID-19 vaccine acceptance challenge and ways of addressing them. The paper utilizes the phenomenological method to investigate the lived experiences of older adults during the COVID-19 pandemic. The findings show that vaccine uptake acceptance and hesitancy are induced by a myriad of factors. Similarly, specific attitudes are fostered by voluntary acceptance and administration protocols. Most often vaccines are disproportionately distributed leading to shortages in certain areas with large numbers of people, inoculators not at designated posts, inadequacy or flaws may be responsible for the inability of those who are prepared to be inoculated in the designated areas to be inoculated, missed inoculation timing, systemic challenges, vaccine uptake hesitancy. Two (2) distinct vaccine uptake pathways pertain in the context of this paper. These pathways are structured around adherence and compliance with inoculation regimes in Ghana, or non-compliance to the same due to diverse COVID-19 pandemic misinformation and/or myths. Five distinct myths pertaining to the coronavirus vaccine were discovered, namely the preservation of older people's

lives for wisdom; vaccine is constituted by protein taken from deceased fetuses; the vaccine does not offer 100% immunity from coronavirus infection; there is the notion that inoculated persons will die in two (2) years of vaccine uptake; finally, hearing of discouraging stories/information impeded vaccine acceptance and the associated uptake. Collectively, these precipitate among older persons feelings of powerlessness and social disintegration which promote a fear of vaccine uptake acceptance, which restricts social participation.

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Introduction

It is a well-known fact that cities, towns, and villages revolve around various activities, from attending weekly church services (Marston et al., 2020) to organising and attending funerals, going to the pub and cinema, among others. These leisure activities are their only connection with like-minded individuals, and their own access to socialisation (Dovie et al., 2019). These have been significantly stalled by the COVID-19 pandemic. Hence, the next available survival means is to take the vaccine while maintaining the other COVID-19 protocols.

Taking vaccination ensures that the inoculated person does not get sick and/or die from infection. As a result, there are diverse types of COVID-19 vaccines produced for inoculation against the coronavirus. These encompass the Pfizer/BioNtech Comirnaty vaccine, the Oxford AstraZeneca vaccine in the United Kingdom; the Moderna COVID-19 vaccine (mRNA 1273); the Janssen/Ad26. COV 2.S developed by Johnson and Johnson; Novavax vaccine; Sputnik V vaccine manufactured in Russia; Sinopharm vaccine is produced by Beijing Bio-Institute of Biological Products Co Ltd, the SII/Covishield vaccine and Sinovac vaccine; Coronavac

developed by Sinovac in China; Covaxin developed by Bharat Biotech in India. Some of these vaccines are characteristically single or double dose(s) in nature (WHO, 2021). It is worth noting that in Ghana out of these, AstraZeneca vaccine, Moderna COVID-19 vaccine and Johnson and Johnson vaccine we are being administrated in the initial phase of vaccine administration based on availability.

Characteristically, this array of vaccines shares similar features with others including standalone features. First, the Pfizer-BioNTech vaccine is a two-dose vaccine based on genetic material called messenger ribonucleic acid (mRNA). Second, the Oxford-AstraZeneca vaccine is a two-dose vaccine which is based on genetic material (this is time deoxyribonucleic acid or DNA) that makes the spike protein. Third, the Moderna vaccine is a two-dose vaccine that is based on mRNA that codes for the Coronavirus spike protein, like the Pfizer-BioNTech vaccine. Fourth, Johnson and Johnson vaccine is a single dose vaccine that is based on the DNA of the spike protein. Fifth, the Novavax vaccine is a two-dose subunit vaccine that is based on the Coronavirus Spike protein. Sixth, the Sputnik V vaccine is a two-dose vaccine that is based on DNA of the spike protein. It is like the Astra-Zeneca vaccine. Seventh, the Sinopharm vaccine is a single dose vaccine that is based on a chemically inactivated SARS-CoV-2 virus. Last but not the least, the Sinovac vaccine is also a single dose vaccine based on the inactivated SARS-CoV-2 virus (WHO, 2021).

COVID-19 vaccination administration in Ghana

Ghana undertook her version of the administration of the COVID-19 vaccine inoculation exercise in March 2021. Overall, 360, 000 individuals received the inoculation between March 1-9, 2021 (Boadu, 2021). These were eligible to receive the second

dose of the vaccine in May 19-26, 2021, that is approximately 10 weeks after the first dose. This is actively meant for people in 43 districts in the Greater Accra, Ashanti, and Central regions. These three (3) regions were the most affected during the initial stages of the pandemic in Ghana and which were affected by the issuance of the lockdown (Dovie, 2021). These were covered in the first and second phases of the vaccination exercise (Boadu, 2021). For the second phase, Ghana received 350, 000 doses of AstraZeneca under the COVAXX initiative in conjunction with existing stock according to President Nana Addo Dankwa Akufo-Addo in his 25th COVID-19 pandemic related address to the Ghanaian nation on May 16, 2021. He admonished that: 'let us take the vaccine when it gets to our turn' (national televised communication, May 16, 2021; Boadu, 2021, p.3).

The president noted that the first phase involved vaccinating a segment of the population in the 43 districts mentioned early on who included health workers, persons with co-morbidities, persons 60+, physically challenged persons, journalists, frontline workers, security personnel and a cross-section of persons in the three (3) arms of government. The second phase entailed vaccination of other health workers across the country. Nearly, a million people have now received the first dose of the vaccination (Boadu, 2021, p. 3). The international vaccine politics in conjunction with the unpredictability of the supply chain alongside the third wave of infections in Europe and Asia (Boadu, 2021) may have impeded the continuous acquisition and access to AstraZeneca and thus the supplementation of the same with Moderna, Johnson and Johnson vaccines. This, however, implies that people who take AstraZeneca for the first time must continue with the same and so on. This implies that having a dose of both is not conducive.

The Ghanaian government's COVID-19 pandemic response strategies are to stop the importation of cases into the country via closure of the nation's borders; containment of cases and slowdown its spread of infections; care for the sick namely people with positive cases; minimization of impact of pandemic related measures - financial issues supported by the Ministry for Gender, Children and Social Protection (MGCSP); boost domestic capacity and self- reliance e.g., produce PPEs locally. In relation to social distancing, there is the possibility that in situations where the center says stay at home and keep social distance, the periphery makes it possible for individuals to do the exact opposite. This is the reflection of uncoordinated governance (Dovie, 2021, p.46).

It has been observed that infections have reduced from 400 to 100 daily (Boadu, 2021). Yet, this should not discourage people, especially the elderly, from participating in the exercise. The president also stated that 'until we vaccinate the requisite numbers of Ghanaians and achieve herd immunity which will help return our lives to normalcy, the imposition of Restrictions ACT 2020, (ACT 1012) will remain in force and the security agencies will not relent in their efforts to enforce it.

There has been 97, 728 infections and 802 coronavirus related deaths reported in the country since the pandemic emerged. However, Ghana has run short of the AstraZeneca vaccines after single dose inoculation of 864, 918 (2.8%) and double dose coverage of 396, 759 (1.3%). As a result, the mode of vaccination has been switched to the acquisition and use of Johnson and Johnson, of which 17, 000 have been obtained (Ghana Television News at 10pm on July 14, 2021). In all, Ghana has administered at least 1, 265, 306 doses of the COVID-19 vaccine thus far, that is about 2.1% of the nation's population with 1, 119 doses administered daily, which implies taking 5, 436 days to inoculate enough people for another 10% of the population (REUTERS,

2021). The World Bank approved $ 200 million COVID-19 emergency preparedness and response project second additional financing (GTV News at 10pm on July 7, 2021).

Drivers and barriers to vaccination uptake

Several factors have the propensity to impede vaccine uptake. The drivers of and barriers to vaccination uptake include logistics, psychological, social, political, and cultural factors. Bruwen et al. (2017) document that the motivation to accept and get inoculated is influenced by various social and practical factors. Other political, social, and economic factors entail the provision of free medical care. For instance, van den Berg et al. (2019) posit that the decision to participate in malaria vaccine trials in three (3) low- and middle-income countries (LMICs) was driven by the provision of health care and community and domestic hierarchies versus individual voices.

Vaccine uptake may be implemented and/or administered under voluntary and mandatory regimes. Most governments across the world have implemented or adopted mandatory vaccine uptake e.g., Australia, France, Italy, U.S.A. (California), Germany with restrictive mandates and as personal non-belief opt-out (Attwell et al., 2021; Eddy, 2019) options. In some cases, fines are imposed to motivate vaccine hesitant individuals and refusers' behavior (Attwell et al., 2021). However, the latter does not balance or create imbalances in choice and liberty with disease prevention (Attwell et al., 2021). Implementation of restrictive mandatory vaccination policies as it is in the case of Ghana is an indication of the exhaustion of a non-persuasive option and elimination of barriers to access. Ordinarily, this is to be turned to when at least other tools and/or options have failed (Omer et al., 2019). This and others may contribute to lower vaccine carnage(s) among elderly

Ghanaians. One way to reduce the number of unvaccinated older adults may be via making exemptions difficult, yet possible (e.g., Omer et al., 2018).

In addition, mandates may not guarantee solutions to the challenge of vaccine refusal (Attwell et al., 2021). Since what works in one setting does not work in others. Yet, the bid to attain targeted vaccine coverage to elicit/ensure community protection (herd immunity) may be legitimate and useful tools dependent on cultural and political acceptability with concerns for individual rights and freedom.

There are a variety of underlying multimorbidity related to the COVID-19 pandemic namely diabetes, heart disease, liver disease, hypertension, kidney, and other chronic diseases (Chee, 2020). The risk of COVID-19 pandemic infection has been observed to be higher for older adults with underlying co-morbidities (Chee, 2020) in particular, given their increased vulnerability to the pandemic.

Misinformation on social media platforms such as Facebook, Twitter, WhatsApp, Internet (Attwell et al., 2021; Dovie, 2019), mobile phone, word of mouth is one of the major barriers to vaccine uptake among the elderly from pro-and-anti-vaccination persons. Collectively, these constitute anti-vaccination strategies' claim of loss of freedom to generate institutional mistrust and proffer the promotion of information on alleged circumstances especially non-proven) safety issues whilst pro-vaccination communication strategies use proven facts and scientific authority to debunk myths and disinformation (Attwell et al., 2021). Understanding the drivers of COVID-19 vaccine acceptance is of global concern, since a lag in vaccination in any country may result in the emergence and spread of new variants that can overcome vaccine- and prior disease-conferred immunity

(Arce et al., 2021). Therefore, the steps required in attaining this objective entail an outline of the issues at hand, which is the impact of the COVID-19 pandemic; the next step relates to the gathering of the necessary information utilizing semi-structured interviews on vaccine uptake and attendant hesitancy in Tema in Ghana's Greater Accra region. This has become necessary because the discussion of the issue at hand provides a unique insight into the situation in Ghana, which to our knowledge has not yet been explored.

Several studies have investigated willingness to take a potential COVID-19 vaccine in high-income countries, and some studies have included middle-income countries (Arce et al., 2021). However, not much is known about vaccine acceptance in low-middle-income countries where large-scale vaccination has yet to begin. Vaccine hesitancy has been observed as a critical challenge to global health (WHO, 2019b) as far as pandemics are concerned. Individual choices, personal contexts, public health benefits and consequences (Demi et al., 2019) pertain to vaccine specific attitudes. In furtherance to these, Attwell et al. (2021) have argued that many studies focusing on vaccine hesitancy and acceptance have been conducted in the more economically advanced countries. "However, we need more studies from low-and-middle income countries that take into consideration their unique characteristics" (p. 190). Thus, this lack of adequate literature justifies the significance of this article. This study sought to explore older people's uptake of the COVID-19 pandemic, especially their perspectives on the reactions or responses to vaccine uptake.

Method

The study was conducted in Accra and Tema in the Greater Accra Region of Ghana. The study adopted interpretive phenomenology to investigate the lived vaccine uptake and hesitancy experiences of older Ghanaians during the COVID-19 pandemic. This approach of phenomenology enabled the researchers to gain in-depth understanding of vaccine acceptance, uptake, and hesitancy in urban Ghana. Noteworthy is that the lived experiences are holistic and interrelated such that it is not easy to delineate one experience from the other. Hence, this study presents findings with intersections between the perceptions pertaining to COVID-19 related vaccine uptake acceptance or hesitancy dynamics among older individuals.

The target population was older Ghanaian citizens who were willing to take part in the study. The study was explained to all the participants and those who volunteered and met the inclusion criteria were selected.

Twelve (12) participants were purposively selected, constituted by six women and 6 men through purposive sampling. Semi-structured individual interviews were conducted in English, audio-taped, transcribed and analyzed using thematic analysis procedures. Examples of questions asked included the following: Could you please tell me more about your life during COVID-19 vaccination exercises? Informed consent was obtained from all participants and rigor was ensured through prolonged engagement of participants in the field and member checking. The ages of the study participants ranged from 60 to 89 years, whereas their educational backgrounds span Middle School Leaving Certificate (MSLC) through to the doctorate degree levels (Table 1).

Table 1: Participant demographics

Respondent	Pseudonym	Gender	Age	Marital Status	Education	Occupation
R1	Essi	Female	67	Widow	Standard 7	Retired
R2	Ametefe	Male	60	Married	PhD	Senior lecturer
R3	Adzo	Female	68	Widow	Standard 7	Retired
R4	Manu	Male	70	Married	PhD	Senior lecturer
R5	Sule	Male	63	Married	PhD	Senior lecturer
R6	Koku Cash	Male	89	Widower	PhD	Retired
R7	Salma	Female	67	Divorced	Bachelor' degree	Businesswoman
R8	Baaba	Female	65	Married	Masters'	Retired
R9	Aweley	Female	77	Married	Masters'	Businesswoman
R10	Lakai	Female	61	Married	A'Level	Businesswoman
R11	Eduah	Male	60	Married	Masters'	Clergy
R12	Lartey	Male	60	Married	Bachelor's degree	Businessman

Source: Field data

Data collection

The individual interviews were conducted in English. The interviews lasted between 40 to 45 minutes. To elicit free individual expressions, open ended questions were posed. Probes were used to gain in-depth understanding of the phenomenon under investigation. The authors collected all the data, whereas the choice of location and time of interviews were at the convenience of the participants. Twelve (12) interviews were audio-recorded with a digital voice recorder with the consent of the participants. These interviews were conducted between March and June 2021. The interviews were transcribed verbatim and field notes were written on context and non-verbal behavior during the interviews. Reflections during data collection were also written as part of the field notes to ensure that the views of the participants of the study were duly represented. The study was conducted at the individual participants' homes and/or chosen locations in Accra and Tema.

Data management and analysis

In this study, concurrent data analysis was undertaken following Collaizzi's (1998) phenomenological processes of qualitative analysis proposed in seven (7) distinct stages namely where all transcripts were: (1) read and re-read to fully understand the lived experiences of the participants. The transcripts were coded, and similar codes were grouped. The authors and an independent person coded the data independently, after which differences were discussed to ascertain a consensus on the most appropriate code for a piece of data. (2) Descriptions were extracted from the transcribed interviews or identified phrases or sentences that were related to the participants' COVID-19 pandemic vaccine uptake and hesitancy lived experiences. (3) The meaning of

each significant statement was outlined. (4) The first three (3) steps for each description, and the creation of themes based on formulated meanings of the descriptions were repeated. Further, themes (e.g., vaccine acceptance; vaccine uptake; vaccine uptake hesitancy were developed and discussed, and discrepancies were resolved by going back to the data and making sure that the themes and sub-themes accurately represented the participants' worldviews. (5) Exhaustive descriptions were integrated from the results. (6) The exhaustive descriptions were summarized to formulate the fundamental structure of the phenomenon; and (7) in the study, trustworthiness was maintained through several processes. First the authors collected all the data which ensured that similar questioning techniques were used. The utilization of the thematic analysis approach ensured that the themes were fully developed. Member checking - asking participants follow-up questions were undertaken as a way of confirming the themes and sub-themes generated during thematic analysis. This ensured that any gaps in the data were filled, and the participants reviewed and confirmed the themes generated as a true representation of their worldviews.

The researchers systematically coded all data and then organized the codes utilizing thematic analysis, based on similarities, into larger and larger categories that led to a hierarchical structure of codes, themes (e.g., myths surrounding issues of COVID-19 pandemic and the associated vaccines - vaccine uptake acceptance and uptake hesitancy) and subthemes (e.g., wisdom). Themes, along with supporting excerpts from the data, were presented in the final report, including the description of those themes in relation to the research questions.

The data was managed with NVivo software version 11. The analytical process proffered by Bazeley and Jackson (2014) was followed in steps. A project comprising all the documents, coding

was undertaken, data and related information that assisted in the process of data analysis while saving the NVivo project was created. The transcribed interview files were labelled and imported. Chunks of data were then coded. This entailed finding obvious themes as well as auto-coding. A thematic multi-case analysis was employed, the comparative concentration of which was on individual cases and the preservation of their uniqueness.

The study sought to address the following research objectives: 1. to assess older adults' acceptance, uptake, and hesitancy of the COVID-19 pandemic vaccine, 2. to discover any myth(s) militating against COVID-19 vaccine uptake among the Ghanaian elderly.

Results

Vaccine uptake acceptance, and hesitancy perspectives

Vaccine acceptance and uptake is facilitated by voluntary acceptance and administration protocols. This is suggestive of the fact that older adults willingly take the inoculation whereas others are equally ready, but the inoculators were not available at the designated locations. This was the situation at Tema Communities 7, 8, and 25. Indeed, the latter induced the reference to Tema as a village by one of the male participants. Owing to this issue others missed the timelines provided per locality, for example, Koku Cash. There was also the display of total vaccine uptake hesitancy.

Taken vaccine

Some of the participants have had a single dose whereas others have had a double dose of the AstraZeneca vaccine. The results also intimated that most often vaccines are disproportionately distributed leading to shortages in certain areas with large

numbers of people. In terms of the location where the vaccination was received, the following revelations were made:

> *I have had the first shot of the vaccine and I am looking forward to receiving the second one* (Manu).
>
> *I had mine at the Korle Bu Teaching Hospital* (Manu).
>
> *I had the first shot of the inoculation at Endpoint. You know, they say the vaccination is to protect we the older people. May be Nana Addo needs to preserve our lives to draw on wisdom from us* (Salma).
>
> *I was at Volta Region at the time, and I had mine over there* (Ametefe).
>
> *When I went to my area, I was informed that the vaccines had run out. I then told my daughter, the one who works at Achimota Hospital, who arranged for me to have my first inoculation there* (Baaba).

Sometimes too, people get vaccinated in areas other than those designated for them due to the shortage of vaccines at such designated locations as it was observed in the case of Baaba. Noteworthy is that intimations above also included the value of older people expressed as a repository of wisdom.

Reactions to vaccination

The reactions to the inoculation were diverse. Therefore, the symptoms experienced after the inoculation entail feeling feverish; joint pains; slight body pains; malaria symptoms within a period of 24 hours, pain at the injection site, swelling at the injection site, fatigue, headache and muscle pain, fever and weakness. These were however managed with the intake of pain relievers such as paracetamol. Bodily reactions experienced after the inoculation have been catalogued in the following voices:

> *When I had the vaccination the first time, I had body pains and felt feverish and weak. As a result, I went to the other woman I went with to take the jab to make enquires and she told me she took paracetamol. And so, I did take some afterwards and got some relief after that. But it was not until after a couple of hours* (Salma).
>
> *The first shot was quite painful. I had to stay in bed for a whole day because I had body pains, felt weak and feverish* (Baaba).
>
> *I had my second shot, and it was normal. I did not have any reaction at all this time around* (Lartey).
>
> *I had my second jab at the same place, and it was not bad - Endpoint* (Larkai).

Absence of inoculators at designated posts

Systemic challenges, inadequacy or flaws may be responsible for the inability of those who are prepared to be inoculated in the designated areas. They said:

> *They have not come to our area yet* (Essi).
>
> *They have not come to my area. I made my daughter to find that out. She said they said they will come and that we will be informed about that later* (Adzo).
>
> *We have not had the first and second jabs because it looks like we are in a village in Tema. We are still waiting for them* (Koku Cash).

Missed inoculation timing

Being ready for vaccine uptake acceptance is as good as the designated timing for it. Stated differently, readiness for the inoculation is as significant as the time designated for it.

Fulfilling one to the detriment of the other is reminiscent of a flawed permutation as being observed.

> *They came to our area, but I missed the timing. When I enquired about the way forward, they said they will come again and that I'd get the chance to have my turn* (Koku Cash).

Vaccine uptake hesitancy

Refusal to participate in the vaccination exercise was fostered by diverse factors namely misconceptions or misinformation, religious beliefs and/or faith. Thus, the participants articulated the following:

> *I do not want to contaminate my body's system with that vaccine. The virus is not my portion* (Essi).
>
> *I would not take the vaccine because there are so many myths surrounding it which are unexplained sources of components of the vaccine* (Akweley).
>
> *I did not take it, so I do not get to contract it from any nurse or health personnel* (Nii Okine).

Myths and misinformation surrounding issues of COVID-19 pandemic and the associated vaccination

This paper highlights the several myths that surround vaccine acceptance hesitancy among Ghanaian older adults. The first myth is that the president of Ghana is prioritising vaccination of the elderly to draw on their wisdom. Indeed, it is about the preservation of lives no matter how old as it amounts to safeguarding their fundamental human rights. The most at-risk category of people has been articulated to encompass older adults and persons with underlying medical conditions. Second, the vaccine is constituted by protein taken from deceased fetuses;

third, the vaccine does not offer 100% immunity from coronavirus infection; fourth, there is the idea that inoculated persons will die in two (2) years of uptake; fifth, hearing of discouraging stories/ information impeded vaccine acceptance and the associated uptake; sixth, vaccine is meant to annihilate humans. These have been vividly articulated in the following quotes:

> *We have heard stories about the ingredients in the COVID-19 vaccine – protein taken from dead fetuses, which we Roman Catholics are strongly against* (Akweley).

> *I am not part of the vaccination. I understand it will create a lot of problems. It is something they want to use to destroy people. I have heard that those who have taken the vaccination, the medical doctors said in two (2) years they will see the effects – many of them will die. Some medical doctors have warned people not to take the vaccine because they know what is behind the vaccine. Besides the vaccine does not offer complete immunity. Even if you take the vaccine, you still must wear the nose mask, etc. So, some of us are out. We have heard so many stories that are discouraging us from taking vaccination* (Sule).

Frontline workers have been fingered as propagating misconceptions about the COVID-19 vaccines. The vitality of maintaining good health was viewed as an important attribute to ageing well. This theme was categorized into three related subthemes: staying alert, having a positive attitude, and modes to keep good mental health. In terms of:

> *Staying alert participants valued their state of alertness related to being independent, having control over their own affairs, and being self-governing. Being alert and having a good memory was mentioned frequently as an imperative dimension of aging well* (Essi).

It is worth acknowledging that being positive was also connected with spiritual merits, having faith, praying, and trust in God; these traits have been mentioned. The participants commented on the importance of reaching a state of serenity and tranquility as an important attribute to ageing well, even in the context of COVID-19. Having a positive attitude emerged as an important attribute to ageing well, and it was diversely characterized.

Discussion

The study sought to investigate COVID-19 vaccine acceptance, uptake and hesitancy among the elderly including the myth(s) militating against COVID-19 vaccine uptake among older adults in Ghana. Two (2) distinct vaccine uptake pathways pertain in the context of this paper. These pathways are structured around adherence and compliance with inoculation regimes in Ghana or non-compliance to the same due to diverse COVID-19 pandemic misinformation and/or myths. These misconceptions can be mitigated by social influence related favorable behaviors such as making social norms favorable to vaccination and/or more salient; highlight new and emergent norms in favor of vaccination, leveraging the role of health professionals; support health professionals to promote vaccination; factoring in endorsements from trusted community members; build timely trust in the vaccines (WHO, 2020).

The findings of this study have implications for the development, implementation, monitoring, and evaluation of tailored strategies to improve and sustain vaccine uptake. These findings also have implications for under-vaccination. Consistent with these findings is the assertion by Arce et al. (2021) that there is a higher willingness in LMIC samples (80% on average) to take the COVID-19 vaccines in LMIC samples compared to the

United States (65%) and Russia (30%). Further, the acceptance of vaccine(s) was primarily explained by an interest in personal protection against COVID-19, whereas concern about side effects was the most expressed reason for reluctance.

The need to get inoculated against infection by the coronavirus became necessary because the pandemic is affecting tens of thousands of people in diverse ways namely the loss of work, the lack of medical care and supplies including food supplies. (Dovie, 2021, p. 49).

Taking the vaccine provides protection against getting severe disease symptoms such as shortness of breath and complications such as pneumonia upon infection. Without the vaccine, an individual could develop severe symptoms and sometimes require hospitalisation and artificial support to breath. In addition, people may suffer side effects, and some of these side effects can interfere with a person's daily activities for a few days. Some of the side-effects of taking the vaccination entail injection site pain, swelling and redness, fatigue, headache, muscle and joint pains, chills, fever, nausea, malaise, and swollen lymph nodes. Different people may experience these differently yet not all these side effects, and these are usually more pronounced after a second shot. However, these are a depiction of normal signs that the body is building the requisite protection and will resolve within hours and up to 3 days. These same effects are also normally seen with many other vaccines. Of the common side effects namely headaches, fever and joint pains, pain relievers such as ibuprofen or acetaminophen were used to relieve this discomfort. It is, however, advisable to speak to medical doctors for further advice. In confirmation, Arce et al. (2021) observed that health workers were the most trusted sources of information about COVID-19 vaccines. As a result, vaccination campaigns in LMIC countries need to focus on translating acceptance into

uptake. This will ensure that messaging highlighting vaccine efficacy and safety, delivered by healthcare workers, may be most effective in addressing remaining hesitancy.

Significantly, ensuring that older people's acceptance of the COVID-19 vaccine is essential, even though the effective and equitable distribution of COVID-19 vaccines is a key policy priority.

After the first vaccination, it is anticipated that the inoculated individuals take the second vaccine between 4 and 12 weeks based on the regime of the vaccine. Noteworthy is that the vaccine has been observed to grant immunity against the coronavirus disease for 7-12 months. The rollout of the inoculation period for Ghana is anticipated to end in December 2021 with an anticipated 20 million people vaccinated in terms of nationwide coverage. The second dose of the inoculation exercise commenced on 19/05/2021 through to 26.05.2021 (Dr. Kwame Achianu of GHS, UTV News May 17, 2021). Ordinarily, the second dose is expected to be received by persons who have had the first dose. (This raises the question as to what the plan is for those who could not receive the first inoculation for various reasons especially in the three (3) designated regions and districts in Ghana). Here, there are two (2) options – either stay intact or move to another location. Older people, the physically challenged, health workers and frontline workers are the first category of persons to receive the inoculation.

The findings of this research particularly the vaccine hesitancy myths are like those in relation to the belief in parts of South Africa that the gang raping of young girls is a cure for HIV/AIDS has been noted as one reason why women are more likely to get HIV/AIDS (Masland et al., 2000). The results also have implications for Ghana's sensitization policy. It may pave the way for changes in global policies. Two distinct groups of older

adults were observed in the context of this paper namely vaccine hesitant elderly and non-vaccine hesitant elderly.

Psychological and behavioral factors worth considering in this context encompass the way people make choices, respond to options, perceive the world, and behave (Attwell et al., 2021, Institute for Government, 2010). In this context, older citizens may fear more than young people do, as they have greater difficulty understanding that ''danger'' is a social construct fed by the attention put on it, which may not be backed up by facts. The increasing commodification of security (by a market for personal security issues, products, and services). For instance, it is indicative that the COVID19 pandemic is one of these contemporary perceived ''dangers.'' This is because they both play an important role in a person's well-being.

Among other things, multi-component strategies that ensure equitable access to vaccination services and quality of vaccination services (as well as training for health care professionals) including interventions to enhance confidence and ensure informal vaccination decision making are prerequisites to the promotion of the resilience for vaccination programs (Attwell et al., 2021).

Research has long found that living in areas with lack of trust among residents may increase the fear (Funk et al., 2007; Sampson et al., 1997; Wyant, 2008) of for instance COVID-19 infection. Social isolation and poor social networks (Hale, 1996) are also bound to affect seniors' perceived safety. (Ceccato & Bamzar, 2016) in this context.

Behavioral responses by Jackson and Gouseti (2012) reported about avoidance behavior, protective behavior, behavioral and lifestyle adjustments, and participation in relevant collective

activities such as vaccine uptake acceptance. Avoidance behavior involves minimizing one's contact with people (social or physical distancing), routine activities, or places. Protective behavior constitutes activities that are thought to prevent crime (putting up fences by being inoculated) as well as wider activities of self-protection and safety improvement. Behavioral and lifestyle adjustments comprise a withdrawal from activities that are dangerous, such as in social gatherings (Ceccato & Bamzar, 2016; Franke & Elliot, 2021).

Conclusion

Two (2) distinct groups of people were observed in the context of this paper namely vaccine hesitant older adults and non-vaccine hesitant older persons. The latter is mostly due to misconceptions and the attendant misinformation about the COVID-19 vaccines. In consequence, vaccine uptake confidence can be attained via awareness creation to increase technical knowledge as well as to generate positive association with vaccine(s). Text messages to mobile phones may serve as a cost-effective way to reach larger populations of older people albeit the entire population to improve health outcomes in the context of the COVID-19 pandemic. Training is required for vaccine counsellors, health professionals and significant trainers. Downloadable intervention resource repository creation is imperative. These could be alone with spillovers for the vaccines – pertussis, influenza, Ebola, HPV, HIV, etc.

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Impact of social isolation in the context of COVID-19 on mental health of older adults in Osogbo Local Government Area of South-Western Nigeria

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Abstract

Traditionally, older persons co-reside with extended family members. The social relationship and structure of the extended family were such that the living arrangement promoted intimacy between older persons and younger family members thereby mitigating the problems of isolation and loneliness in old age. However, this living arrangement was altered by one of the COVID–19 mandates - social isolation, imposed by the federal and State governments in Nigeria during the pandemic. This was with a view to limiting in-person visits and lowering the risk of COVID-19 infection. As important as this approach was, there were also concerns that social isolation may increase risk for anxiety, cognitive decline, dementia, and depression among older adults. Although research has been conducted on COVID-19 directives in Nigeria, studies which, considered the impact of social isolation on mental health in older adults who, traditionally rely on and cherish time spent with friends and family members are sparse, hence this study. Utilizing qualitative data from in-depth interviews with older men and women, the paper examined the impacts of one of the COVID-19 mandates on mental health of men and women aged 60 years and older; identified the factors responsible for mental health challenges in older adults in social isolation and investigated the strategies

they adopted to cope with the identified mental health issues due to social isolation during the COVID-19 lockdown in Nigeria using Osogbo Local Government Area as a case study. The study showed that social isolation enforced by the federal government and state governments had negatively impacted on mental health of older adults in the study area. These findings are linked to movement restriction, stay-at-home and self-isolation orders that had made it impossible for children and extended family members to visit their aged relatives during the lockdown. The coping strategies employed include prayers, regular telephone conversations with family members, reduction in watching of television and observation of COVID-19 protocols, among others. Pragmatic policy options aimed at addressing this emerging mental health problem in older adults were highlighted.

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Introduction

Since it was first discovered in Wuhan City, Hubei Province, China in December 2019, the coronavirus disease of 2019 (COVID-19) has been sweeping through many parts of the world that generate a global health problem endangering human existence (WHO, 2020a). In January 2020, the World Health Organisation (WHO, 2020a) declared the outbreak of the disease a Public Health Emergency of International Concern (HEIC) and on March 11, 2020, the WHO (2020b) made the assessment and pronounced the virus a global pandemic. As of April 21, 2020, 89 countries with more than a third of the global population experienced lockdowns due to the outbreak (Global Health Research Policy, 2020).

Following the spread of the virus, the Federal Government of Nigeria also mandated all its citizens to observe the COVID-19

protocols such as the stay-at-home order, social distancing, and self/social isolation during the period. These directives have forced everyone to become more socially isolated more than ever before. However, the effects of social isolation among older adults have been found to be more distinct as they have more dreadful consequences than among people of other ages. It is not surprising therefore, that like in every country battling with the COVID-19 outbreak, older people in Nigeria were specifically directed to self-isolate and shut themselves off from other people who might risk infecting them. It is believed that this segment of the population is most vulnerable to the COVID-19 pandemic, due to their weaker immune systems and higher likelihood of having chronic underlying ailments such as heart disease, diabetes, lung disease and cancer. It was also strongly believed that having any of these conditions is a risk factor for suffering complications from COVID-19 (Wu, 2020). In many countries, whimsical direction taken by this deadly disease has led to massive mental health problems across all ages (Nair, Tripta, Appu & Aneesh, 2021). However, the effects of social isolation among older adults may be more pronounced and have more dire consequences than among people of other ages. The negative impacts of social isolation in later life have been widely reported, ranging from declining mental and physical health to reduced quality of life, increased mortality, and higher Medicare costs (Luo, Hawkley, Waite & Cacioppo, 2012).

While some studies have shown that diseases like COVID–19 pandemic has had an unprecedented negative effect on the lives of older adults especially those with multiple associated co-morbidities, (Weiss, Mays & Martz, 2005; Mohan, Sahana, Amit, Amita, Nandini, Murtaja, & Kakali, 2021), others have also indicated that social isolation has an unmatched harmful consequence on older adults such as anxiety, panic, adjustment

disorders, depression, chronic stress, and insomnia as the major offshoots (WHO, 2021; Eboiyehi, 2021).

Little wonder that the World Health Organization (WHO, 2021), reports that social isolation among older adults is becoming a growing public health concern, which have been made more salient by the COVID–19 pandemic. Social isolation is defined as the objective state of having few social relationships or infrequent social contact with others (Wu, 2020). In other words, it is a feeling that one does not belong to the society in which s/he lives. In the traditional African society, an older adult was part of the society and as such did not suffer social isolation. According to Fajemilehin (2000), s/he knows no poverty, deprivation, malnutrition, loneliness, neglect, or isolation. In Nigeria, as in other sub-Saharan African countries, older adults are known to co-reside with members of the extended family. The social relationship and structure of the extended family were such that the living arrangement promoted intimacy between older persons and younger family members thereby, reducing the problems of isolation and loneliness among older adults in the evening of their lives (Oyeneye, 1993). Furthermore, it is also believed among Africans that family members who live in multigenerational households are incredibly strong as other extended family members including spouses, children, grandchildren, brothers, uncles, and other kin groups are always there to surround him or her at the twilight of his or life (Eboiyehi & Nwuzuirigbo, 2014; Eboiyehi, 2021). The advantages an older adult enjoys including healthcare provision, financial support, and shared meals. By this, the physical, economic, social, and emotional needs of older persons are met through this informal network (Fadipe, 1970). Aside from extended family members, an older adult also interacts, interrelates, and intermingles with other members of the communities (Abbate, 2016; Eboiyehi, 2021). Prior to the outbreak of covid-19, they also actively participated

in many social activities, such as attending meetings, churches activities, marriage ceremonies, traveling, and many other social events. Their connection to others also enables them to survive and thrive. That is why Jomo Kenyatta (1965) in his book *Facing Mount Kenya* stresses that in African traditional society, "nobody is an isolated person. Primarily, s/he is several people's relative and several people's contemporary."

Unfortunately, the intergenerational relationships as described above have come under the influence of exogenous forces such as lockdown, stay-at-home, social, or physical distancing as well as self or social isolation directives, which have restricted an older adult to a corner in his/her room (Eboiyehi & Nwuzuirigbo, 2021; Otaki, 1998). Although social isolation is legitimate during the time of the outbreak of COVID-19, it also has a significant negative impact on older adults' mental health status. Eboiyehi (2021) argues that if social isolation of older adults is not managed or reviewed, the close intimacy which the older adults enjoy may be reduced leading to depression and other mental health issues. In other words, social isolation during covid-19 could make matters worse for older adults who may not only be struggling with greater health risks but may also be less capable of supporting themselves when they are cut-off from family members. Eboiyehi (2021) and Muoghalu and Eboiyehi (2021) Thus, the mental health conditions of older adults worsened during the COVID–19 social isolation. Eboiyehi (2021) and Muoghalu and Eboiyehi (2021) in their studies in south-west and south-east Nigeria respectively, also found that COVID-19 protocols significantly reduced the levels of interconnectedness and intermingling among the elderly and their family members in their study areas. Other studies on social isolation in later life conducted elsewhere (Aishwarya & Pradeep 2021; Mohan, Sahana, Mit, Amita, Nandini, Murtaja & Kakali, 2021) also found that social isolation is a serious public health risk that affects a

significant number of older adults which puts them at higher risk of suffering negative outcomes which may lead an elevated rate of serious mental medical health conditions. In other words, social isolation during COVID-19 could make matters worse for older adults who are not only struggling with greater health risks but may be cut-off from the entire society including family members and friends. Although studies have been conducted in Nigeria on COVID–19 and older people (Eboiyehi, 2021; Muoghalu, 2021), the ones which considered the impact of social isolation in the context of COVID-19 on the mental health of older adults are sparse; hence this study. The overall objective of this study, therefore, is to contribute to the literature on the on-going discourse of coronavirus pandemic as it affects the mental health of older adults in Nigeria, using the Osogbo Local Government Area of southwestern Nigeria as the study area. The specific objectives are to:

a. examine the impact of social isolation on the mental health of older adults during COVID–19 in Osogbo Local Government Area.
b. identify the factors contributing to the mental health of older adults in isolation in the study area; and
c. investigate the coping strategies they employed in dealing with the identified mental health issues while in isolation.

Method

Research design

The study is basically qualitative using in-depth interviews. In all, 32 in-depth interviews (QTIs) comprising 16 males and 16 females aged 60 years or older were conducted. An interview guide was developed to moderate the discussion and validated through pre-text among similar participants in Eleweran

community in Ile-Ife. Actual data collection was conducted between April 30 and May 25, 2021, after the 2020 lockdown and stay-at-home directives imposed by both the Federal and Osun State Governments were lifted. Each interview required an average of 45 minutes to conclude. Where interviews could not be completed, they were rescheduled at the instance of the interviewees. Because of the high and low level of literacy among the study population, all in-depth interviews were conducted in English and Yoruba languages.

Study setting

The study was conducted in Osogbo and involved older men and women from different sociocultural groups in Nigeria. Osogbo Local Government Area (LGA) serves as the state capital of Osun State and administrative Centre for the Local Government Council (LGC). It is in southwestern Nigeria and consists of notable areas like Aiyetoro, Alekuwodo, Dada Estate, Fagbewesa, Idi Seke, Ata Olokan, Kola Balogun, Odiolowo, Oke Oniti, Okefia, among others. Osogbo lies on latitudes 07 40' north and longitude 04°30° east. It also lies along the Osun River at a point on the railroad from Lagos, 180km southwest and at the intersection of road from Osogbo, Ogbomosho and Ile-Ife. It also shares a common boundary with Ibadan (northeast), Akure (northwest), Ikirun, LGA, Ilesa LGA, Ede LGA, Egbedore LGA and Iragbiji which is the administrative seat for Boripe LGA. According to United Nations (UN, 2021), the city has a population of 731, 000 at 3.8% growth rate. It is a trade centre for farming in the southwest region. Yams, cassava, grains, and tobacco are grown there. Cotton is grown and used to weave cloth. In 1988, about 27% of the population were engaged in farming as their primary occupation, 8% were traders and about 30% clerks and teachers (Agbola, 1992). However, there has been a reduction of farming population due to an increase in educational enrolment in the

area. Four urban communities (UC) and 4 rural communities (RC) namely, Okefia, Omo West, Kola Balogun and Aiyetoro (urban), Ota Efun, Ita Olokan, Fegbewesa and Idi Seke (rural) were purposively selected. These communities were chosen because of their high concentration of older adults with significant number of migrant population and ethnic heterogeneity which presents a context where people from diverse backgrounds come together to work and do business. In each of the selected communities, 4 older men and 4 older women participated in the study. In all, 32 in-depth interviews (16 males and 16 females) were conducted.

Sampling procedure

The sampling procedure adopted in this study was purposive through snowballing method where the head of the community and an interviewee suggested another interviewee within his or her area. The in-depth interviews were conducted based on the interviewees' willingness to participate in the study. The interviewees who were engaged in the study were those that were satisfied with the criteria of age (60 years or older), sex (male and female) and ethnic group (Yoruba, Igbo, Edo, Urhobo, Iteskiri and Akwa Ibom origins who are residing in the study area at the time the study was conducted). The information provided by the interviewees was recorded while relevant notes were also taken where necessary. The collected data were later translated and transcribed for further analysis. Analysis of data followed two approaches, namely, ethnographic summary and systematic coding via analysis to accommodate verbatim quotations.

Ethical considerations

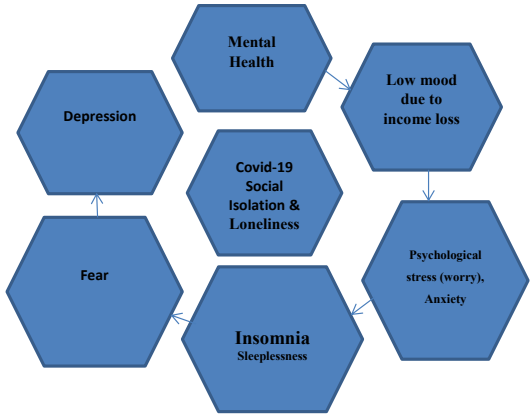
In compliance with ethical standards on research involving human subjects, the principle of ethics governing human research was observed with the aim of protecting the dignity and privacy of every individual who, during the data collection phase

offered valuable information about himself/herself or others. Considering the sensitive nature of the study, the researcher sought and obtained the consent of the following people: chairperson of the Local Government Area LGA), community heads and older people themselves. The prospective interviewees were introduced to the researcher by the local government chairperson with the assistance of community heads who informed them of the purpose of the research. The objectives of the research and its anticipated benefits were carefully explained to all the participants prior to the commencement of the study. The request for anonymity and confidentiality was respected. Only older people who showed their willingness to participate in the study and who voluntarily gave the researchers their phone numbers were included in the study.

Results

Impacts of social isolation on mental health of older adults during Covid-19

Figure 1: Impact of social isolation on older adults



Source: Adapted from UN Policy Brief: The impact of COVID–19 on older persons.

During the in-depth interviews, the interviewees were asked about how social isolation impacted on their mental health. The prevalence of anxiety, depression, insomnia (inability to sleep or poor-quality sleep), psychological stress (worry) and loneliness were mentioned as shown in fig. 1 above. For example, a 67-year-old male interviewee at Ota Efun said:

> *The period of isolation was very stressful to me. I felt as if I was alone in the whole world. In fact, it had devastating impact on my mental wellbeing. At a point, the Doctor had to call my children for fear of me going into depression. Thank God it was effectively managed. I was emotionally disturbed because I have never been alone since I was born. I could not sleep properly throughout the period I was in isolation.*

Yet, a widower at Ita Olokan aged 71 years stated as follows:

> *My inability to see my children and grandchildren who were around me made me physically and emotionally sick. They have been my rally point since my wife died about five years ago. I also felt the absence of my relatives who have always been at my beck and call. With their continuous support and presence, I did not feel the absence of my wife as I would have felt after her demise. So, you could see how being alone could be upsetting because there was nobody around me to share my thoughts with. This experience gave me something to worry about.*

Correspondingly, a female interviewee at Fegbewesa aged 64 years affirmed:

> *The thought of death or losing a loved one made me feel troubled and distressed while I was alone in the isolation centre. These fears were compounded by the different kinds of rumors I was receiving about the disease which were not also helping matters. This affected my mood and was always feeling agitated. Because*

> *I was not sure of what will happen the next minute, I found it difficult to sleep well because of fear, apprehension, and anxiety, which affected my mental state of health.*

Similarly, a man at Idi Seke aged 74 years stated:

> *Being socially isolated for so many weeks affected my mental disposition. This is because it affected my economic and social life. For example, I could not go to farm during the period. My farm and cocoa plantation were covered with bush and there was nobody to help me attend to them. The thought of losing my crops, inability to see my friends and family members had negative impacts on my mental wellbeing.*

Factors contributing to mental health challenges of older adults in social isolation

On identifying the factors responsible for mental health challenges in older adults in isolation in the study area, the following causes were identified by the interviewees: fear, anxiety, stress, rumors about the disease, inability to be visited by friends and family members, worry about the economic and financial loss, fake news, stigma attached to those infected, loneliness and the non-availability of personal protective equipment (PPE) for medical personnel. All these factors they said gave them concerns about their future as well as the future of their family members and relatives during the isolation period. For instance, a male interviewee at Omo West area of Osogbo, aged 66 years old lamented thus:

> *I must tell you that being in isolation for almost three and a half weeks was not easy. This is because you do not know what will happen that moment, talk less of surviving till the following day. To worsen my situation, news was flying about that older people*

> *like us do not survive COVID-19 infection. The most fearful one is the number of deaths announced on the television and those that I read on social media. Throughout the time I was in isolation, I thought about my survival and those I left at home, particularly my wife, and my entire household. These alone gave me anxious moments, fear and depression that affected my mental health.*

A 65-year-old retired Accountant from Osun State University at Fagbewesa remarked:

> *Staying at home 24/7 in the name of self/social isolation or as you may choose to call it lockdown was not easy at all. You may call it isolation, but I prefer to call it imprisonment. Loneliness was a major factor that gave me sleepless nights. Even our creator does not like loneliness and that was why after creating Adam, He quickly created Eve because He thought Adam would have run mad if he was alone in the Garden of Eden. How could one stay at home 24/7 when he is not a cripple? It drove me mad. Inability to visit my friends and family members or for them to pay me visits was a major challenge. This was compounded with inability to go to farm, market and even go to hospital to attend to my heath issue. I can tell you; it was one of the major life challenges I have ever experienced since I was born some 62 years ago. All these experiences generate stress and anxiety that affected my mental health.*

Some interviewees said they were worried about the monetary loss they incurred during the period of lockdown and isolation. For instance, a 67-year-old mechanic who was residing at Kola Balogun and who had not been able to conduct his business due to social isolation and lockdown directives imposed on populace stated as follows:

> *When I was in isolation, I lost substantial income because I have not been able to continue with my business while I was there. This gave me a lot to worry about. In fact, I was traumatised.*

In addition, a female interviewee, a retired Secondary School teacher who lived at Aiyetoro and aged 70 years acknowledged:

> *Reading fake stories about the virus on media made me sick, helpless, and hopeless. This fake news such as deaths as COVID-19 being perceived as a death sentence coupled with stigma being attached to those that have been infected, the non-availability of personal protective equipment (PPE) for medical personnel gave me negative feelings and intensified my worries.*

Coping strategies

Managing mental health and psychosocial well-being during isolation period is as crucial as managing one's physical health throughout the COVID–19 period. When interviewees were asked to respond to the question on how they managed their mental health and psychological well-being during the period spent in social isolation, the following coping strategies were mentioned: "maintenance of social networks with friends and family members", "limitation of physical social contact with others", "ensuring that only accurate information were received", "connecting with family members and friends through telephone", "social media and video conference", "engaging in regular exercise", "keeping regular sleep procedures", "eating appropriate and healthy food", "occupying oneself in prayers and reading the word of God:, among other strategies. For instance, a female interviewee who was residing at Omo West, and aged 62 years stated:

> *Although it was tough, I still managed to weather the storm and cope well. You can see it is only my wife and I that are living in this house. Our children are not living with us though some are here in Osogbo while others are within and outside the country. My major coping strategies are to ensure that I stayed connected*

> *with them and other family members (both nuclear and extended). In other words, I ensure that I called them regularly. Aside that, I made sure that I rested well by having good sleep, eat good food to boost my immunity. They say one can be infected if his or her immunity is low.*

According to a male interviewee who was a retired Secondary School Principal, aged 66 years (Aiyetoro):

> *Although I was worried, I ensured I observed all the COVID–19 protocols such as limiting physical and social contact with people to avoid being infected. I also advised my relatives to stay away from me though we were communicating always through telephone, social media, and video conference. These strategies were very helpful, and they made me survive the trying period.*

Yet, another male interviewee at Kola Balogun area, aged 72 years asserted:

> *I reduced watching television and listening to all kinds of rumors about COVID-19 to avoid hypertension. I was only seeking information from my doctor and my children who were only advising me on what to do. Apart from that, my children were very wonderful during the period of isolation. They were supplying all the necessary things I needed: food stuff, drugs, clean water and call regularly to know the state of my health.*

In addition, a 65-year-old female interviewee at Kola Balogun said:

> *Some palliatives sent by the government and support from good people in my neighborhood had assisted in reducing the stress that could have arisen during the period of isolation.*

Yet, a male retired University lecturer, now a farmer at Fegbewesa and aged 71 avowed thus:

> *I tried as much as possible to increase reading stories that are encouraging, particularly those that have to do with the survivors of COVID–19. These have gone a long way in reducing stress, worries and anxiety. Also, the practical and emotional support I got from my family members was helpful.*

Correspondingly, a male businessperson living at Okefia, aged 65 years asserted:

> *I engaged in regular exercise. I also ensured that I ate appropriate and healthy food, slept, and rested very well and occupied myself with prayers and reading the word of God. I believe in prayers, and I am of the view that it is only God that can save and restore our health and heal our land from this deadly disease. Most importantly I keep to my doctor's advice to avoid anything that could worsen my mental and physical well-being during the time of isolation. This includes the use of tobacco, alcohol, or other drugs.*

One of the male interviewees at Ita Olokan who is also a retired civil servant, aged 68 years also stated:

> *The best way I handled the situation was taking a lot of vitamin C, Zinc, turmeric and ginger milk, black seeds and ensured I had a lot of fruits like watermelon, cucumber, vegetable, and local herbs at home as a way of preventing being infected by the virus. I was doing a lot of reading of books, newspapers, and magazines and more importantly, I ensured that I observed all the COVID-19 protocols such as regular washing of hands with soap, avoiding touching my face and contaminated surfaces as well as following social distancing and wearing of a mask, particularly when I went out to do physical exercises.*

Discussion

This study was conducted a few months after the COVID-19 pandemic lockdown was relaxed. It is therefore timely in the sense that it focuses on the impact of social isolation on the mental health of one of the most vulnerable groups in the country.

The study is qualitative using in-depth interviews to elicit information from older adults who were socially isolated during the COVID-19 lockdown. Specifically, the study examined the impacts of social isolation on the mental health of older adults during COVID-19 mandates; identified factors responsible for the mental health challenges of older adults and investigated the coping strategies they employed in dealing with mental health issues they encountered during the period in Osogbo Local Government Area, Osun State in Southwestern Nigeria. The study plainly demonstrated that social isolation had negatively impacted the mental health of older adults in the study area during COVID-19 period. It argued that though social isolation is critical in protecting the older adults from contracting the coronavirus, it was found that it has had negative impact on older adults' social relations as they were unable to actively participate in many social activities, such as attending meetings, church activities, marriage ceremonies, traveling, visit or receive visitors religious as well as participating in economic and political activities, which they were used to. As family members were compelled to obey these orders, the social values that hold African families together were cut off which can also have all sorts of negative consequences for older adults ranging from depression, anxiety, low mood to increased mental health problems. This finding corroborated the assertion of (Albert & Cattel, 1994; Eboiyehi & Onwuzuruigbo, 2014; Eboiyehi, 2021) that living arrangements with other family members in multigenerational households had a way of strengthening the intergenerational relationship.

Eboiyehi (2021), also observes that was possible because in traditional African society, spouses, children, grandchildren, brothers, uncles, and other kin groups were always there to cater to the basic needs of the older adults. However, the study indicates that the social and self-isolation due to COVID-19 has altered these kinship and social networks. This can be attributed to the fact that the number of uncles, cousins, aunts, and other members of both the nuclear and extended family significantly declined during the COVID-19 lockdown period.

There is no doubt therefore, that most of the interviewees affirmed that they would not be able to survive if they were separated from their family members (i.e., their caregivers) and friends. Thus, if social or self-isolation directive is fully implemented by the governments and adhered to strictly by older adults, family members and friends, they would not only suffer loneliness but mental health illnesses. These findings are in tandem with Muoghalu and Eboiyehi (2021) and Tappenden and Tomar (2020) studies. While Tappenden and Tomar (2020), in their study on "Mental health impacts of Social Isolation in older people during COVID-pandemic, found that overwhelming feelings of isolation or loss of social relations with friends and family members had contributed to the cognitive decline leading to low mood, psychological stress, anxiety, worry, insomnia, fear and depression and sensitively to threat; Muoghalu and Eboiyehi's paper in 2021, on "the effects of COVID–19 pandemic on the mental health of the elderly Igbo in two selected local government areas in Anambra State of South-eastern Nigeria" found that during the lockdown, older people mentioned difficulties in meeting their friends, family, relatives, and missing social participation as major factors that contributed to mental health disorder. This was also found to have led to the worsening of pre-existing loneliness and social isolation in older adults.

The study has also indicated myriads of mental health challenges associated with social isolation of older adults during COVID-19 in the study area. Health anxiety, panic, adjustment disorders, depression, chronic stress, and insomnia were identified as the major offshoots. Fear of fear of death, contracting the disease, difficulties in meeting friends and family members as well as difficulties in accessing health facilities, farm, market, healthcare centers were commonly reported by the participants as contributing factors. These findings validated the study in Korea by (Kang, Bae, Kim, Shin, Shin, Yoon & Kim, 2017), that fear, depression, loneliness, and anxiety during the time of isolation in their study area did not only affect physical health but also adversely affected their mental health. In addition, the studies conducted in China, UK have also shown that prolonged loneliness, and isolation have a serious public health concern as it increases the prevalence of depression, anxiety, stress, and insomnia in older adults (Brooks, Webster, Smith, Wesseley, Greenberg, Rubbin, 2020; Qiu, Shen, Zhao, Wang, Xie, & Xu., 2020).

On the coping strategies employed in dealing with the mental health problems due to COVID-19, the participants reported many ways in which they managed the stressful conditions. While some of them reported staying connected with family members by way of making regular telephone conversations, others said they ensured they had adequate rest and sleep, consumption of local herbs, reading of Holy Bible and Holy Koran, eating balanced diet to keep healthy, reading newspapers and magazines to reduce stress, watching television, listening to radio and music, and reading other Christian books during the period. Other coping strategies identified include reducing the watching of television and listening to all kinds of rumors surrounding COVID-19. While some of the participants maintained that they relied on seeking COVID-19 information only from their family doctors

and their children as well as limiting physical and social contact with people to avoid unnecessary worries, others reported they engaged in regular exercise, observed COVID-19 protocols such as regular washing of hands with soap, avoided touching face and contaminated surfaces as well as following social distancing, and wearing a mask in crowded places if they had course to go out to do physical exercises.

Conclusion

The study concludes that social isolation of older adults during COVID-19 period negatively affected the mental health in older adults in the study area. The main mental health effects recounted include depression, emotional disturbance, stress, anxiety, rumors and misinformation, low mood, fear, depression and insomnia, and bad news about COVID-19 during the period spent in isolation.

Recommendations

The impact of social isolation on the mental health of older adults is deep and weighty. It is thus critical to direct our attention to the needs of this segment of the population who are more vulnerable to COVID-19 as well as highlight measures to be taken to ensure that members of society can keep themselves safe from the virus. In this respect, the study offers the following recommends:

- There is a need to strengthen social connections using telephone and video chats.
- There is a critical need for effective communication and community engagement to combat misinformation and fear-related behaviours;

- Older adults need to observe regular physical exercises that will help to stimulate their mental wellbeing.
- There should be an urgent need to incorporate mental health and psychosocial support needs into the COVID-19 pandemic response;
- Psychosocial supports which include other interventions must continue during and after the pandemic. In this case, there is need to focus on the vulnerable and high- risk groups like those who survived the virus infection, bereaved family members and older adults themselves who had lost their family members;
- Older adults should be advised to have adequate sleep and regular sleep and eat good food;
- Telephone hotlines or online consultations should be provided by the three tiers of government in every community to ensure older adults' rapid access to health care services: and
- Traditional medium of good quality information familiar to older adults should be introduced at every community to mitigate their COVID-19 stress.

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COVID-19 Pandemic and the Elderly in Ghana- A Discussion of the Religious and Spiritual Implications for Their Wellbeing and Survival

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Abstract

The years 2020 and 2021 have been challenging for the elderly globally because of the unimaginable impact of COVID-19 pandemic on that age group. According to a report by the US Center for Disease Control and Prevention, the greatest risk for severe illness and death from COVID-19 is among those aged 85 or older. In this presentation, I wish to establish that religion and spirituality are essential mechanisms for the elderly to cope during crisis situations such as the COVID-19 pandemic. This paper will draw on a body of research which has shown a positive correlation between the wellbeing of the elderly and their spirituality or religiosity. This paper also seeks to discuss the spiritual needs of the elderly and suggests best approaches to provide care to meet their spiritual needs during the pandemic. This presentation would also highlight some results from an open-ended questionnaire survey administered to pastoral caregivers of the elderly in some selected Presbyterian church congregations in Ghana. The survey results provide evidence on how the elderly maintain their spirituality even under strict COVID-19 restrictions. Finally, this presentation will also highlight some pastoral care guidelines necessary for the promotion of the well-being and quality of life of elderly people during this COVID-19 pandemic and in future.

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Introduction

The increasing population of the elderly globally has caught the attention of demographers, development planners and other social scientists. According to the UN Report of 2017, the population aged 60 years or overreached 962 million worldwide. This figure is more than double the 382 million recorded for the same population in 1980. It is projected that by 2050 the number will reach 2.1 billion (Department of Economic & Social Affairs Population Division, 2017). The 'United Nations Plan of Action' on ageing discussed this population phenomenon and stated explicitly that:

> *From 1975 to 2025, the number of persons aged 60 years and over throughout the world would increase from 350 million to over 1,100 million, or by 315% compared with the total population growth of 102%. By 2025, ageing would constitute 13.7% of the population* (UN, 1982, p, 1184).

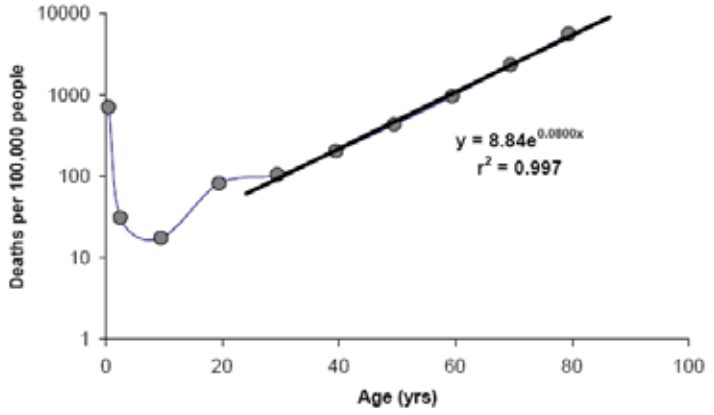
Interestingly, two thirds of older persons live in developing regions. In 2050, it is projected that 8 in 10 of the world's older persons will be living in the developing world. In many countries in the developing world, the general conditions of the elderly in terms of the availability of good healthcare facilities and modern amenities for the promotion of their wellbeing are below those prevailing in the developed world. In the era of COVID-19 where availability of better equipped medical facilities, healthcare personnel and vaccines are a necessity, older people in the developing world become more vulnerable if they become infected with the virus. Thankfully, the rate of infection in countries in Africa and other developing countries is not alarming, compared with some of the more advanced countries (UN, 2022).

Ageing defined

Ageing is a multidisciplinary subject, and can be defined from different perspectives, for example, psychological, physiological, chronological, and spiritual. It can simply be defined as a set of changes in the human being associated with the progress of time.

Most evolutionary biologists define aging as an age-dependent or age-progressive decline in intrinsic physiological function, leading to an increase in age-specific mortality rate and a decrease in age-specific reproductive rate (e.g., Medawar, 1955; Rose, 1991; Williams, 1957). Aging therefore has been defined as the collection of changes that render human beings progressively more likely to die (Medawar, 1952). Mathematically, ageing can be quantified from mortality curves as shown in Figure 1 below:

Figure 1. Mortality rates, expressed in deaths per 100,000 people, as a function of age for the 2002 US population.



The Impact of the pandemic on the elderly

Globally, the aged population has been severely impacted by the COVID-19 pandemic. According to a report by the US Centre for Disease Control and Prevention the greatest risk for severe illness and death from COVID-19 is among those aged 85 or older (Center for Disease Control & Prevention, 2021). Besides the high mortality rate among the elderly, the lockdowns increased the period of isolation and loneliness suffered by the elderly (WHO, 2022). The result of such prolonged isolation- either in hospitals or in aged-care homes - cannot be easily assessed, but without doubt the mental health of some of the elderly would have been affected. Additionally, access to the general healthcare system was sometimes limited to only 'emergency doctor visits' during the peak of the pandemic. This would mean that routine medical check-ups or regular medical visits to the hospitals is critical to the wellbeing of the aged would be limited.

The COVID-19 protocols enforced a controlled visitation scheme for families visiting the elderly- in sheltered, residential and private homes, especially in the developed countries. The restrictions were directed towards a reduction of contacts with the elderly to prevent infections among the elderly who were most at risk.

In rural Africa, however, where most elderly people live with their families, the elderly did not suffer much isolation and loneliness compared with their counterparts in urban centers in Africa who may be living alone after the demise of a spouse. Nonetheless, the economic impact of COVID-19 suffered by both urban and rural dwellers in Africa would exacerbate the already deplorable conditions of many elderly people on the continent. The situation has been reported in some articles and papers written recently. Writing on "The Impact of COVID-19 Pandemic

on the Elderly in Africa" Martin R. Rupiya wrote in ACCORD Magazine:

> *"A major feature of COVID-19 has been its impact on income, both in the formal and informal sectors. Its effect has been most evident in family links and informal trade. This includes remittances from the diaspora, as millions join the unemployed in areas where popular village or town square markets have been shut down, eliminating a key feature of the revenue stream of informal settlements* (Rupiya, 2020*)."*

In a related article Catherine Caruso wrote about the worsening of the economic conditions of the elderly in Mozambique because of COVID-19 and the effect of Cyclone Idai (Caruso, 2020).

During the onset of the COVID-19 pandemic, in-person gathering for worship in churches was suspended by lockdowns and COVID-19 protocols. Consequently, the frequency of religious rites and sacraments for the elderly were reduced (especially Communion services, celebration of birthdays and organization of funeral services etc.). In churches in Ghana, government directives encouraged older adults and individuals with underlying health issues to stay at home during Sunday chapel worship after the lockdown was lifted.

Other forms of impact included the fear of approaching death and death of close friends. The mere experience of friends dying around you or one being in a critical health situation can create fear of death- imagined or real. These are general occurrences experienced during old age but heightened during the COVID-19 pandemic.

The coronavirus pandemic impacted negatively on global economy, leading many nations to experience unprecedented economic recession. The consequences of this economic challenge

resulted in hardship suffered by many individuals including the elderly (Van Jaarsveld, 2020). The reduced income of the private sector where some of the elderly belong, coupled with reduced remittances from relatives affected by the COVID-19 pandemic exacerbated an already precarious situation faced by many elderly people. In places where elderly farmers or landowners could not work because of the restrictions, the dependency ratio was high. In situations where retired elderly persons were not on any pension, poverty resulted (Li et al., 2020).

Ageing, spirituality and religion

There is an increasing awareness and interest in religion, spirituality, and wellbeing of the elderly. This is evidenced in many studies and discussions on spirituality, religion, and ageing. It is appropriate at this juncture to define the concept of spirituality, religion, and faith development.

There is no simple definition for spirituality, but many attempts have been made by different scholars to define or explain it. Howard Clinebell defines spirituality as "*the human need for meaning and value in life and the desire for relationship with a transcendent power*."

Spirituality holds together the emotions, convictions and attitudes that characterize an individual's life history. It is what people live by and which helps them to look forward. Spirituality is also seen as an inner resource that animates, drives, and motivates the person. It brings together the person's sense of meaning and relationship worked out with others and, if the person has faith, with God. This concept of Spirituality is reinforced by the National Interfaith Coalition on Ageing (NICA) which adopted the definition:

> Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness. (Moberg, 2012; NICA, 1975).

Mowat and O'Neill (2013) noted that there are two schools of thought regarding the concept of spirituality: a) It pertains to religious belief; b) It pertains to people's need for meaning, which can be found in faith in a divine entity but also in their relationships with others (Mowat & O'Neill, 2013).

Religion on the other hand can be described as a belief in and worship of a supernatural power, especially a personal God or gods. It is a personal set or institutionalized system of religious attitudes, beliefs, and practices.

The Royal College of Nursing (RCN), in its pocket guide on spirituality in nursing care (RCN, 2011), explains that spirituality is not just about religious beliefs and values, but also about hope and strength, trust, meaning and purpose, forgiveness, love and relationships, morality, creativity and self-expression (RCN, 2011). For many people spirituality can be situated in religious practices within an organized group such as a Christian church. According to MacKinlay (2017) 'spirituality can be mediated through a relationship, a conversation, a landscape or a work of art as well as through religious practice and rituals.'

James Fowler helps us to comprehend the development of spirituality connected with faith with his **'**Faith Development Theory'**.** Fowler divided the whole life span into seven eras: Infancy, Early Childhood, Childhood, Adolescence, Young Adulthood, Adulthood and Maturity. According to Fowler, each stage of life has a corresponding stage of faith development. For example, Adulthood and Maturity (60+) correspond with the Universalizing Faith. Older Adults at this stage of development

'are selfless and open-minded and attempt to live a life which represents a vision of the absoluteness of love and justice in a future and universal commonwealth of being'. While they may not be perfect in all their ways, the cause for which they commit their being is an admirable quality. At this stage, it is also important to understand how faith and spirituality produce positive health outcomes for the elderly.

Research on the importance of religion and spirituality for the elderly

Numerous studies indicate that the spirituality and religiosity of the elderly play a vital role in cushioning them during times of crisis or distress.

Research from over 1,200 empirical studies and 400 reviews by Koenig and colleagues (1994, 2001) has shown evidence of a positive correlation between faith and religious practice and health benefits, including protection from illness, coping with illness and faster recovery (Fowler, 1981).

Studies suggest that spirituality (and religion) have been helpful for persons with physical disorders. For example, elderly patients who are spiritual have utilized their beliefs in coping with illness, pain, and life stresses. Some of the studies indicate that those who are spiritual tend to have a more positive outlook and a better quality of life. These studies are recognised and supported by the World Health Organisation (WHO). The WHO Consultation on Spirituality, Religion and Personal Beliefs released the following statement to emphasize the critical need to factor spirituality and religion into the health care needs of people:

> *'Health professions have followed a medical model which seeks to treat patients by focusing on medicines and surgery and gives less importance to beliefs and to faith. This reductionist or*

> *mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope, and compassion in the healing process. The value of such 'spiritual elements in health and quality of life has led to research in this field to move towards a more holistic view of health that includes a non-material dimension, emphasizing the seamless connections between mind and body'* (WHO, 1998).

Research has found a positive relationship between various measures of religiosity or spirituality and high levels of morale, life satisfaction, psychological health, successful ageing, and other indicators of well-being. According to a study, religion and spirituality has been found to provide psychological benefits to the elderly (Kaplan & Berkman, 2021).

Many elderly people report that religion is the most important factor enabling them to cope with physical health problems and life stresses (e.g., declining financial resources, loss of a spouse or partner). In one study in the US, more than 90% of elderly patients relied on religion, at least to a moderate degree, when coping with health problems and difficult social circumstances. For example, having a hopeful, positive attitude about the future helps people with physical problems remain motivated to recover (Sadler & Biggs, 2007).

There are many other published reviews that indicate empirical findings linking religious variables to psychosocial and health-related results in gerontological and geriatric research (Koenig, 1995; Koenig et al., 2001; Levin, 1997). There are also epidemiologic investigations of religious effects on mortality/longevity/survival (e.g., Hill et al., 2005; Hummer et al., 1999; Krause, 2006).

In other studies, there has been more correlation between spirituality and positive outcomes among the elderly. For example, McCullough et al. (2000) suggested that people who participate in spiritual activities such as going to church as individuals or in groups often live longer than those who do not (McCullough et al., 2000). In another instance, Erichsen and Büssing (2013) found a relationship between meeting the spiritual needs of older people and positive health outcomes (Erichsen & Büssing, 2013). There is also published evidence of a link between spirituality and mental wellbeing (Cornah, 2006).

A cross-cultural study carried out by the author on pastoral care provision for the elderly has revealed the importance of religion and culture in the wellbeing of the elderly in Ghana (Ayete-Nyampong, 2008). Many other studies suggest that religion/spirituality has been very helpful for persons with physical disorders. Patients who are religious have utilized their beliefs in coping with illness, pain, and life stresses. In an article published online, the authors confirmed that:

Research on the biology and neurobiology of pain has given us a relationship between spirituality and pain. There is growing recognition that persistent pain is a complex and multidimensional experience stemming from the interrelations among biological, psychological, social, and spiritual factors. Patients with pain use several cognitive and behavioral strategies to cope with their pain, including religious/spiritual factors, such as prayers, and seeking spiritual support to manage their pain (Ozden & Kaptan, 2013).

Some of the studies also indicate that those who are spiritual tend to have a more positive outlook and a better quality of life. For example, patients with advanced cancer who found comfort from their religious and spiritual beliefs were more satisfied with their lives, were happier, and had less pain (Puchalski, 2001).

Results of a pain questionnaire distributed by the American Pain Society to hospitalized patients showed that personal prayer was the most used non-drug method of controlling pain. 76% of the patients made use of it. In the study, prayer as a method of pain management was used more frequently than intravenous pain medication (66%), pain injections (62%), relaxation (33%), touch (19%), and massage (9%), (Puchalski, 2001).

To further explore how religious influences enhance wellbeing and coping mechanisms during old age, I interacted with a group of older persons after a Sunday morning church service at the Larteh Salem Congregation of the Presbyterian Church of Ghana. The study involved 36 females and 9 males aged above 65 years present at the church service that Sunday morning. Data was collected through a group interview. Results from the study showed that 90% of the respondents considered prayer as a powerful spiritual exercise that kept them going daily; it was also their source of strength and healing; by it they had easy access to the Almighty God who sees their needs and is ever present in their situations.

Motivation for religious participation (in-person) during COVID-19 pandemic

In a post-lockdown study conducted to investigate the motivation for church attendance by the elderly during the COVID-19 pandemic in some selected Presbyterian Congregations in Ghana, pastors asked through a survey to identify factors that motivated aged members to attend church services regularly. Some elderly members of the congregations were also interviewed directly about the same subject. The data from this study revealed interesting responses which revealed that belief in God and one's personal spiritual life coupled with the need for satisfaction were

the key motivation for the participation of the aged in church services amidst the ravaging impact of the COVID-19 pandemic. Some responses from the study are categorized and highlighted subsequently.

- FAITH IN GOD- it is the central attraction to worship in church. As Africans, this belief is innate and regulates social norms.
- FELLOWSHIP AND SOCIALIZATION- these are the antidote to loneliness, boredom and isolation suffered at home during the week (Monday to Saturday).
- SECURITY AND PROTECTION IN CHURCH- the church environment offers the elderly security and protection from any abuse some of them suffer from their relatives at home.
- SACRAMENTS AND RITES SUCH AS HOLY COMMUNION- these identify one with the faithful. Holy Communion becomes the last rite administered to the dying believer.
- SPIRITUAL NOURISHMENT/ WORD OF GOD- it is the food of the soul and guiding principle by which life is lived in its fullness (John 10:10). The Word of God is also described as the sword of the Spirit with which the elderly overcome temptations and spiritual attacks (Ephesians 6: 10-15).
- TO FINISH WELL IN FAITH- Having begun the Christian race in infancy, there is a motivation during old age to finish well and receive the crown of righteousness (2 Timothy 4: 7-8).
- TO RECEIVE HEALING FROM GOD- the Bible assures Christians in Isaiah 53: 5b that by the stripes of Jesus we are healed. The elderly who are more susceptible to coronavirus infection and other age-related physical weaknesses join in worship to receive healing and deliverance from God.

- PRAYER SUPPORT- they constantly crave prayer support and enjoy congregational intercession for the elderly, sick and bereaved.
- CHURCH MUSIC- one important motivating factor for church participation is the music that soothes, encourages, and strengthens the soul. It is the medium through which they bring praises and thanksgiving to God.
- VIRTUAL ACTIVITIES NOT FAVOURABLE FOR ELDERLY- most elderly people are not accustomed to modern technology such as the use of Zoom or Facebook for virtual church services. In-person worship services are preferable and beneficial to the elderly.
- FEEL PROTECTED AGAINST THE VIRUS WHEN IN CHURCH- congregations comply strictly with the COVID-19 protocols. Some elderly people feel safer and protected from the coronavirus when they are in church than when they are at home or in their communities where there is often a total disregard to government directives on face masks, social distancing and washing of hands.
- CHURCH ATTENDANCE IS A HABIT SINCE CHILDHOOD- Church attendance has been a habit since childhood, and non-participation would only occur in periods of severe illness or disability.
- LOVE FOR CHRIST-it is the chief motivation because Christ died for sinful humanity and resurrected to assure us of eternal life with God.
- TO BE ACTIVE IN CHURCH PROGRAMS- this is where the elderly utilizes their giftings and contribute to the growth of the church.
- TO BE REMEMBERED IN CASE OF CRISES/ DEATH; HELPS PREPARE FOR DEATH- going to church keeps them

in memory of the congregation for continuous support and other benefits.

- COMING TO CHURCH IS EXERCISE- the walk to church is a routine exercise that promotes good health.
- RELIGIOSITY BRINGS PEACE OF MIND AND WELLBEING- they have peace within themselves when they maintain a lively spiritual life, knowing that humans are made of body, soul, and spirit in communion with God who is Spirit.
- THEY RECEIVE COMFORT AT CHURCH- in times of losses and bereavement, the church offers a lot of support and comfort through the hymns, visits, donations, and words of encouragement.
- THEY GIVE TITHES AND OFFERINGS- bringing their gifts of tithes and offerings to God is a practice that promotes their relationship with God and the church.
- LOCKDOWN CLOSURE OF CHURCHES WAS SEVERE BLOW- the closure of churches during the lockdown was a severe blow that robbed them of most of the benefits enumerated above.
- GOING TO CHURCH SHOWS A GOD-FEARING NATURE AND REVERENCE TO GOD- changing into a Sunday clothing and going to church gives one a healthy feeling of the fear and love of God.
- DEPENDENCE ON GOD- being in church to pray and worship shows dependency on God.
- THE ILLITERATE LISTEN TO THE READING OF THE BIBLE AND PREACHING- inability to read the Bible is not a disability to prevent the knowledge or study of the Bible. In church the Bible is read as part of the lectionary and preached. It is an avenue to acquire knowledge and information.

Spiritual needs of the elderly

Having considered the above reasons or motivation for participation in church services after the lifting of lockdown restrictions, one becomes convinced that need satisfaction of the elderly becomes a compelling factor associated with religiosity and spirituality. Linking this finding to Abraham Maslow's Hierarchy of Needs which identify five main blocks of needs: Physiological needs, safety needs, love and belonging, esteem, self-actualization, it is easy to posit that during the pandemic, the elderly have also relied on religiosity and spirituality as a safety net to meet certain basic needs for survival and self-actualization (Maslow, 1943).

Additionally, Rev. Albert Jewell also identifies six spiritual needs of the elderly, Albert (2003):

- **Association (non-Isolation)** - Humans are social beings and need companionship and friendship.
- **Affirmation** - We all need to feel that we are of value and use in life; that we are wanted, loved, and needed.
- **Celebration** - This is an instinct. Without room for celebration life becomes a burden.
- **Confirmation** - Older people need someone who will simply listen and allow them to share their deepest feelings.
- **Reconciliation** - Older people often say they 'want to die in peace'- with others, with their own heart and with God.
- **Integration** - Feeling that one has been an active part of life.

Koenig (1994) identified 14 spiritual needs of older people based on prior research both at a theoretical and empirical level. Koenig focuses here on religion and the various practices that emerge from participation in religion (Mowat & O'Neill, 2013).

This distinction is noteworthy because the word 'spirituality' has been associated with different meanings and arguments. This list below includes:

i. Need for support in dealing with loss
ii. Need to transcend circumstances
iii. Need to be forgiven and to forgive
iv. Need to find meaning, purpose, and hope
v. Need to love and serve others
vi. Need for unconditional love
vii. Need to feel that God is on their side
viii. Need to be thankful
ix. Need to prepare for death and dying
x. Need for continuity
xi. Need for validation and support of religious behaviours
xii. Need to engage in religious behaviours
xiii. Need for personal dignity and sense of worthiness
xiv. Need to express anger and doubt

Practical steps to enhance the spirituality of older adults during COVID-19 pandemic

In an article on '*Spirituality and Care for Older People*', Janet Parker underscored the importance of providing the spiritual environment in which older persons can deal with their many challenges such as losses and mending of broken spirits through love, service, and prayer. How these losses are dealt with is important to their well-being (Parker, undated).

The problem statement is: how do we promote the wellbeing and need satisfaction of the elderly during the COVID-19 pandemic

using their spirituality and religiosity as the basis for developing a life-enhancing model of pastoral care?

This paper proposes the use of the Church's 3-core functions: ***Kerygma, Koinonia*** and ***Diakonia.***

Kerygma and its associated word ***Didache*** imply the preaching and teaching of the Word of God to build the spirituality of the worshipper through hearing and living by the Word of God. There are many promises in the Bible that assure an elderly person of the love and care of God during the period of health challenges and losses in old age. For example, Isaiah 46:3-4 assures the elderly of God's care and assistance in old age:

> "Listen to me, you descendants of Jacob, all the remnants of the people of Israel, you whom I have upheld since your birth, and have carried since you were born.
>
> Even to your old age and gray hairs.
>
> I am he; I am he who will sustain you.
>
> I have made you and I will carry you.
>
> I will sustain you and I will rescue you." (Isaiah 46: 3-4)

During sickness, one can easily meditate on verses that promise healing, such as **Isaiah 53:5**:

"But he was pierced for our transgressions, he was crushed for our iniquities; the punishment that brought us peace was on him, and by his wounds we are healed."

In a pandemic period, the elderly would benefit from the Word of God, preached, taught, read, and discussed in church. If circumstances permit, special 'gerontological hermeneutics could be developed to the spiritual needs of the elderly. In situations where hearing is impaired, sign language could be adopted by trained volunteers.

The ability to meditate on the Word of God brings calmness and peace even during grief, illness and diminishes in old age. A Religious/ spiritual person ought to have time each day for prayer, Bible reading/ study and reflection. This is a good spiritual exercise with many health and psychological benefits.

John Piper, author of 'Coronavirus and Christ' agrees with the benefits of meditation by quoting that "God has not destined us for wrath, but to obtain salvation through our Lord Jesus Christ, who died for us so that whether we are awake or asleep we might live with him. (1 Thess. 5:9–10)".

J. Kwabena Asamoah-Gyadu in his book 'Christianity and Faith in the COVID-19 Era- Lockdown Periods from Hosanna to Pentecost' has added another dimension to the discussion on meditation by encouraging a reflection on the Church's history through periods of crises such as the Lockdowns from Hosanna to Pentecost. This take gives us a healthy approach to mitigating crises situations in life such as COVID-19.

Koinonia

Fellowship is an important part of the ministry of the church because it promotes sharing together and participation in the lives of one another and with God (1 Corinthians 10: 16-18). The essence of ***koinonia*** is to be a therapeutic community where sharing and participation promotes healing and integration. This could be enhanced by intentionally forming an adult group for socialization and recreational activities.

Adult social/recreational group

This group is needed to discuss matters relating to the spiritual, social, psychological, and physical needs of older adults. All

COVID-19 protocols should be followed. The meeting place ought to be 'elderly friendly' to facilitate easy access for wheelchair users and those with difficulty in walking and climbing.

At their meetings lunch could be served, and games and play items should be available to encourage recreation and relaxation and limit loneliness and boredom.

An example of such a group is '**Mission 50 Plus**', a group of older adults formed in the Accra Ridge Church. This group meets regularly to engage in activities that enhance wellbeing and quality of life.

Liturgy and worship in Church

Besides the social and recreational activities planned for the elderly during the pandemic and post-pandemic era, the consciousness to promote the spiritual needs of the elderly should translate into pragmatic steps to make worship more meaningful and inspiring for the elderly members. This calls for a review of the traditional way of worship during church services for the mixed group of church members. In this regard, the following practical measures could be adopted:

- Church services ought to be short and inspiring.
- Older adults should not be made to sit on hard pews for long hours.
- The public address systems need to be loud enough but not too loud.
- Chapels and church offices should be easily accessible.
- Sacraments and Prayer sessions should feature frequently.

An environment which creates a conducive space for worship and fellowship offers the potential of ameliorating any concomitant impact of the pandemic or ageing on the life of the elderly.

Diakonia

The Greek word ***diakonia*** implies 'to serve'. It is used here to represent an organized practical service to the elderly to enable them to have certain necessities or to be able to manage certain domestic duties that they had been unable to perform due to their physical disability, frailty, or illness.

The notion of **d*iakonia*** should not connote a passive, lazy and dependent impression about the elderly. It is heart-warming to note that in many cases where volunteers are enlisted for charity work and domestic assistance, the able-bodied elderly are first in line to undertake such responsibilities as a way of keeping themselves active- physically, psychologically, and spiritually. This elderly will benefit by using their gifts, talents, and wisdom to serve God and to help fellow older adults and others in the church or community.

Pastoral visitation

Pastoral visitation (or visit) implies the taking of Christ's love by a representative of the Christian community to another person in his or her experiential and situational context so that the response elicited by this reception will promote the well-being of the receiver and enrich that of the giver. Pastoral visits are an important part of the ministry of the Church because they serve as the hinge on which hangs the door which opens to bring in grace, healing, sustenance, reconciliation, and guidance into people's lives.

Many contemporary writers have given much space to pastoral visits. This has reflected their theological orientations. For example, Thomas C. Oden emphasized this work of the pastor (Clergy) in his or her shepherding role. According to Oden, one

main goal of pastoral care is achieved through visitation because it is how realistic shepherding can be brought in touch with 'parishioners actual loves and aversions, joys, and sorrows, hopes and fears. According to Oden a pastor can easily intervene and empathize during direct encounters on visitation (Oden, 1983).

Pastoral visits of the elderly in Ghana

Visiting the elderly at home during the pandemic can be beneficial if it is well executed by pastoral visitors who have the right theological orientation and understanding of the benefits of pastoral visits. This section adopts a contextual approach to visiting elderly people in the Ghanaian context and ensures that all necessary COVID-19 protocols are implemented.

First, it should be remembered that a communal pastoral care approach involves both clergy and laity in a shared vocation as they participate in God's praxis to bring love and the eventual realization of the Kingdom of God in people's lives. In this approach, participants are trained and adhere to basic principles of establishing rapport and maintaining helping relationships during the pastoral visits. It is a reflective action guided by the minister whose 'after visit' engagement with the pastoral carers includes sharing feedback to develop new strategies and goals for future visits (Ayete-Nyampong, 2014).

Concept of visits in Ghanaian culture

Professor Kwasi Dickson has clearly stated that: "It is a commonplace that the sense of community is strong in Africa" (Dickson, 1984). This sense of community, evident in the interconnectedness and strengths of relationships, is always maintained and expanded by the human activity called visitation: the movement of people into other people's contextual situations

(their places of living or where they can be found, and within their experiences). The goal of these visits is always to maintain relationship by promoting the well-being of the visited whilst the visitor is also enriched by the positive outcome of the visit.

The Akan word for visiting is *Kǫ sra* (to visit). *Kǫ sra* means to go to anoint, an indication that within the Ghanaian community, visiting implies bringing to another person blessings in the form of nourishment, healing, spiritual strength and sometimes guidance and correction in the person's life-journey. Thus, *Kǫ sra* implies going into a person's situation to bless him or her.

In about eighty-two references in the Bible to the word *visits*, *visitation*, and *visited*, only in a few instances is the meaning connected to visiting for the purpose of punishment. The rest of the visitations are for good-will or blessing; even those related to punishment are for correction to restore and maintain the relationship between God and man, and between persons. This is also beneficial. The clearest picture in the Old Testament which matches with the Akan view is the story of Samuel going from Ramah to Bethlehem to anoint Jesse's son (David) as king in place of King Saul (1 Sam 16: 1-15). Verse 13 is the climax of the visitation:

> "Then Samuel took the horn of oil and anointed him in the midst of his brethren; and the spirit of the Lord came upon David from that day forward. So, Samuel rose, and went to Ramah." (1 Sam 16:13)

Samuel's visit to anoint David is simply a human participation in God's work to bring blessings to another being. The ecclesial praxis has its reference point in God's praxis, and the individual pastoral carer is equipped with the church's authority in the name of God. Therefore, whatever benefit is derived is seen as coming from God (Wingo, 2006).

The mutuality in pastoral care very often manifests itself within the context of visitation. In this nourishing experience of the receiver, the giver (visitor) is also blessed by the visit. In Ghana most people show their appreciation by thanking God and then thanking the human person supposedly used as a divine instrument of blessing. The word 'thank you', has a deeper meaning than is apparent. The Larteh people in Akwapim (Eastern Region of Ghana) express its meaning more succinctly: "*mkpe gyi wu le*" (life be to you). This word of thanks depicts the understanding that whatever is received during visitation, or any goodness done has the aim of promoting life and well-being, and the best way to express gratitude is to share the life received with the giver. In this sense, the visitor and the visitor share the fruits of the labour.

During the visit establishing a rapport with the family and elderly

The beginning of a visit is as important as its end. It is natural that most people do not easily open to visitors till they are assured that their well-being is a priority. Greeting by shaking hands, with family members and the elderly in the house, is a sign that the visit is for a peaceful purpose (1 Samuel 1:1-2:10).

Another way of establishing rapport is to accept the drink, which is served to welcome visitors, and to enquire about the health of all the family gathered. In my pastoral work experience, it was observed that sometimes unplanned visits were very boring and did not elicit the desired response. Some of these visits were so brief that all the attention was focused on the elderly person without considering the presence of the small or large group of family members gathered around. Since most elderly people live within an extended family setting, establishing a

good relationship with the family can guarantee good social support for the elderly. In all these visits, the giving of gifts such as toiletries or money should be the last item on the agenda otherwise some elderly people and their families could be so overwhelmed by the gifts and act or respond artificially to please the visitors. These gifts should not be equated with the essence of pastoral visits, because the greatest gift is the pastoral presence itself.

Religious rituals and sacramental worship

Africans are very religious. The presence of representatives of the Church presupposes the presence of the divine (Supreme Being). Pastoral visitors need to share with the Christian elderly people a form of the church's worship. This can take the shape of singing favorite hymns of the elderly or praying together with them (and their family if they are available). Finally, prayers can also be said for the church and its work, including pastoral visits. Sometimes, the elderly person may want to participate in the prayer. He or she may be asked to pray for the church-its life and work. In performing any ritual or partaking in the sacrament of Holy Communion, it is always a good idea to give thanks (with the family around) for the life of the elderly person. This is a living experience of what I term 'anticipatory death tribute'. At least the elderly person experiences, whilst still alive, a testimony of his or her long life. He or she may also, from that time, begin to appreciate his or her life as worth living and become conscious of the need to expand any remaining resources for the commonwealth and principle of being. It also prepares him or her to anticipate death gracefully.

Story telling in pastoral visits

The Christian faith is embedded in the story of God visiting humanity to redeem it. The narrative forms an integral part of Christian proclamation. In a short but informative article on 'Storytelling and Pastoral Care', Tim Eberhardt, a pastoral theologian at McDonald, Tennessee, described stories as the stuff and the language of life. Eberhardt believes that in all activities of mankind there is a narrative forming and unfolding, and these stories define our worldview and give us our identity.

> "*All of life is patterned by story. Our seeing, hearing, touching, smelling, tasting, questioning, imagining, understanding, realizing, reflecting, pondering, wondering, and judging are inter-woven with our story. Stories define who we are and what is important to us. The stories we hear, read, watch, or tell influence our world view. Story is, in short, the language of life*."

In pastoral visits to the elderly, the Christian story is retold by the presence of the pastoral visitors. The elderly person may also be allowed to tell his or her own story. This story telling is likely to evoke two responses: 1) the opening of hearts to Christ's redeeming work; 2) sharing and celebrating the elderly person's life.

Although the two stories- divine and human- may not have much in common, the story of the divine in human history may be an inspiration for the ageing, to reflect and lead the rest of their lives in anticipation of apprehending the Kingdom of God and experiencing eternal life now and after death. This may take the form of a ritual liturgy for preparing for ultimate death and seeking reconciliation and forgiveness for one's past life.

Conclusion

Although research to explore the linkages between spirituality and ageing is new, the benefits of spirituality and religiosity to the human person have long been recorded in sacred books. The religious life of many elderlies has enabled them to cope with the harsh realities of life, especially during the pandemic.

The religious and 'spiritual elderly' in times of pain and loneliness, pray to God for healing and comfort or to be taken to the peaceful and beautiful paradise where no pain exists.

Religion and Spirituality serve as enabling mechanism for healthy ageing and contentment even during COVID-19 pandemic. To enhance the benefits of spirituality for the general wellbeing and quality of life of the elderly, the church set out to engage in practical and therapeutic activities using its three core functions of ***Kerygma*** (and Didache), ***Koinonia*** and ***Diakonia.***

Pastoral visitation will serve as a pastoral activity to bridge the gap between church worship and home living of the elderly. It connects the lonely and isolated elderly with the church community through the representative Christian persons involved in the pastoral visits. The visits would enable the pastoral carer the opportunity to officiate in rituals, worship and storytelling with the elderly and provide practical support and encouragement for the well-being and fulfillment of the elderly and their families.

Finally, with the full deployment of the resources of the church- both physical, social and spiritual, elderly people would be able to sustain a satisfactory life experience, wellbeing and quality of life and above all have their spiritual needs met in ways that would manifest in what Albert Jewell has already described as: Association- non-isolation in socialization; Affirmation- feeling

valued and wanted; Celebration– recognizing achievements in life; Confirmation- being listened to and sharing deepest feelings; Reconciliation– living and dying having achieved peace with others, with their own heart and with God; Integration – being fully active in life.

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Ageing Without Social Security and the COVID Pandemic in Ghana

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Abstract

Provisioning for the aged remains problematic in developing countries due to the absence of reliable social security systems that cater for majority of the population who operate under precarious conditions in the informal sector. How did the aged cope with existential costs before and during the COVID pandemic? This paper discusses insights on the care of the elderly, their coping mechanisms, and obligations of the State as a duty bearer. Methods used for the study include a cross-sectional survey and qualitative semi-structured interviews in 2019 and follow up in 2021. Findings show that the elderly experience poverty through lack of income, lack of food and ill-health. Less than a third could meet their living expenses, and over 60 percent of them continued to work in old age for their upkeep, and by relying on family support in challenging times. The State as a duty bearer was absent in the care of the aged. The COVID pandemic compounded their situation through jeopardised social relations, emotional stress, economic hardship, and fear of patronising health facilities for regular care. The paper concludes that there is a lack of reliable social safety net for the care of the aged, except those who worked in the formal sector and are therefore covered by the national social security scheme. However, over 70 percent of the working population operates in the informal sector. The paper recommends establishment of a universal social security system to guarantee the welfare of the

elderly and set up specialised units within the health care system for the elderly.

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Introduction

The elderly population continues to rise steadily in the global North and South. Indeed, the United Nations Department of Economic and Social Affairs (UNDESA) reported in 2019 that there were 703 million people aged 65 years and over world-wide. This number is projected to double to 1.5 billion by 2050 (UNDESA, 2019, p.1), constituting 16 percent of the global population. This represents a significant revision of earlier projections by the World Bank (2013) that elderly persons, aged 65 years and over, would constitute 8-9 percent of the total world population by 2050. In Ghana, the elderly population, 60 years and over, has increased seven-fold from the 1.5 percent in the 1960s to 7.2% of the population in 2019 (GSS, 2019). This paper discusses the living conditions of the burgeoning elderly without pension income and their coping mechanisms, in view of statutory expectations from the State as a duty-bearer regarding the care of the elderly.

This challenge of increasing life-expectancy in the face of dwindling savings for retirement is forcing a rethink and redesign of post-retirement social security schemes (Morgan & Lothia, 2017). For example, Finland has introduced a guaranteed pension system which pays 713.73 Euro per month to qualifying beneficiaries, to ensure a minimum level of pension income for those who do not have any other source of official pension income (Kuivalainen et al., 2018). This was aimed at strengthening social security which the International Labour Organisation (ILO Convention 102, 1952) defined as the protection society provides

to households and individuals to enable access to health care, income to guarantee a reasonable standard of living during old age, unemployment, sickness, invalidity, or survivor benefits.

Globally, the number of people with effective access to at least one social security benefit ranges from 84.1 per cent in Europe and Central Asia, to 67.6 per cent in the Americas, 38.9 per cent in Asia and the Pacific, and 17.8 per cent in Africa, less than 1 in 5 persons (International Social Security Association, 2019, p.15). A study by Van Ginneken (1999, p. 179) also indicated that coverage rates of social security in most developing countries ranged between 10 to 25 percent, and in sub-Saharan Africa and South Asia, more than 90 percent of the population were not covered. This was due to erratic incomes and uncertainties faced by informal sector workers, which severely constrained their ability to contribute regularly to social security schemes (Van Ginneken 1999, pp.1-11). Given the situation of workers in developing countries where most of the labour force operates in the informal sector, the number of people covered by social security has remained extremely low (Nyanguru, 2003; Van Ginneken, 1999).

The difficulties associated with pension coverage in economies with large informal sectors have also been well-articulated by Kidd (2009), arguing that universal pension schemes funded from general fiscal measures have better possibilities to succeed in developing economies than pensions funded from pay-roll taxes, since most workers operate in the informal sector in such economies. The informal sector situation unfavourably impacts income security and results in lack of stable income to sustain a decent material standard of living (ILO, 2018) or reduces the ability to meet basic human needs such as physical and psychological health, including nutritional food, a home, social participation, and self-esteem (Dean, 2010). It has also

been shown that the elderly with higher education tend to have more income or more favourable social security at retirement in developed societies (Alstead et al., 2019); and that formal employment increases access to social security, implying that the higher the number of people working in the formal sector, the greater the likelihood that more people will be covered by social security (Kuivalainen et al., 2018). In Africa, Nyanguru (2003) revealed that in Lesotho, 50 to 70 percent of the elderly were not covered by any social security and lived on incomes which were less than the minimum wage in both urban and rural areas. Some non-contributory schemes do exist in a few African countries including South Africa, which is financed from general revenues of the State, but the provisions offered are still considered inadequate to meet needs of the elderly (Gumede, 2017).

Previous studies on the elderly in Ghana focused on several dimensions; these include the work of the leading gerontologist Apt (1995) which argued that financial constraints and inadequate housing have worked together to curtail the capacity of families to cater for elderly relatives as they did in the past. This, she argues, has created a situation where elderly relatives have come to be seen as liabilities rather than integral members of families. Studies by Kumado and Gockel (2003) and Nukunya (2003) have articulated the importance of the extended family in the Ghanaian society as backup to individuals or the nuclear family in times of financial difficulties or other distress. However, the capacity of the extended family has been severely eroded under the economic pressures of contemporary times, with dire consequences on vulnerable family members, especially the elderly. Sossou and Yogtiba (2015) have pointed to the problematic welfare situation of the elderly in Ghana such as pervasive poverty, illiteracy and subjection to unacceptable cultural and religious practices which denigrate and dehumanise them in parts of the country.

Curiously, it is the poor and powerless elderly women who are subjected to such abuses, whiles those in stable economic circumstances are remain untouched, revealing an unwelcome association between poverty, gender, and susceptibility to abuse in old age. Recent work by Kpessa-Whyte (2018) confirmed the continuous weakening of the traditional family support system and its detrimental impact on the elderly due to urbanisation, socio-economic hardships, and processes of globalisation in Ghana, and the inability of the retirement system to cater for their needs. Recent studies have also pointed to inadequacies regarding the health care of the elderly and called for expansion of the exemption policy for the elderly under the National Health Insurance Scheme (NHIS) to include all vulnerable persons and all persons aged 60 years and over, instead of only those 70 years and above (Fenny, 2017). Awuviry-Newton et al. (2020) have also explored feelings of abandonment and neglect experienced by the elderly in Ghanaian society.

This paper contributes to the scholarship shedding further light on how the elderly experience poverty and cope with living expenses, followed by a juxtaposition of the findings vis-à-vis international, regional, and domestic legal provisions and policies regarding the care of the elderly. With this point of departure from earlier studies, the research questions of this paper were as follows: How do the elderly experience poverty, and how do they cope? Do the support systems available to them meet the obligations of the State as a duty bearer under international, regional, and domestic statutory provisions and policies regarding the care of the elderly? Furthermore, how did the COVID-19 pandemic affect the elderly and how did they cope?

The paper proceeds as follows: the subsequent section discusses the statutory provisions which serve as an analytical framework

to assess the performance of the State in meeting statutory obligations towards the elderly. This is followed by the methods, findings, discussion, and conclusion.

Statutory provisions on social security for the elderly

Internationally, social security remains a basic human right as enshrined in the Universal Declaration of Human Rights (UDHR) of 1948, the International Covenant on Economic Social and Cultural Rights (ICESCR) of 1966, United Nations Principles on Older Persons of 1991, and ILO convention 102 (1952). The UDHR which was adopted and became operational in 1948, states in article 22 that every member of society has a right to social security. Article 25 (1) of the UDHR also states that everyone has a right to a standard of living which is adequate for their health and well-being including food, clothing, medical care, and the right to social security in the event of old age or other life eventualities beyond their control.

These provisions under the UDHR clearly emphasis the place of social security as a right which must be respected and persons in old age are specifically mentioned in article 25(1), leaving no ambiguity about the place of social security for the elderly. State Parties to the UDHR bear the duty to ensure that these provisions are respected, but many have shifted this responsibility unto individuals or to non-State actors, who undertake such responsibilities as charity (UNFPA, 2012). As much as such organisations have become the only resort for many vulnerable persons, the State remains the legal duty-bearer to ensure social security. However, several reports on the social security situation in the world have raise questions about the effective performance of this duty by States especially in developing countries (ILO, 2018; ISSA, 2019).

The International Covenant on Economic, Social and Cultural Rights (ICESCR) which was adopted and opened for signature by State Parties in 1966 eventually came into force in 1976. Article 2 of the ICESCR states governments who are parties to the convention recognize the right of everyone to social security, including social insurance. Article 11 of the ICESCR also provides that governments take appropriate steps to ensure realisation of the tenets of the convention. Here, there is a clear, unequivocal duty imposed on States to ensure that these rights are made available to citizens and is further articulated in article 2 of the ICESCR which states that party to the Covenant take steps to progressively achieve full realization of the rights, particularly the adoption of legislative measures. These provisions make clear the responsibility of States to ensure a decent standard of living for its citizens spelling out the necessities of adequate food, clothing, and housing, and to take legislative or statutory measures to ensure that these were provided. Whiles developed societies have made reasonable strides in this direction, developing countries have lagged, or implemented policies that benefit only a small section of the population (Adesina, 2011; Mkandawire, 2012).

The United Nation's principles on Older Persons (46/151) adopted in 1991, enjoins State Parties to ensure independence, care, self-fulfilment, dignity, and participation of older persons, but doubts have been raised by the preparedness of States to implement these provisions. Thus, there are strong legal obligations on States that have duly signed and ratified these statutory instruments to implement the enshrined rights and provisions as duty-bearers. However, the social security situation in the developing world, especially regarding the elderly, casts significant doubts on the realization of these rights.

The ILO established the minimum standards for social security in 1952, stipulating that social security must cover medical care, benefits in case of sickness, unemployment, old age, and employment injury. Furthermore, ILO Convention 102 enjoins social security schemes to consider family size, maternity, invalidity, and widowhood, and make provision for both contributory and non-contributory systems (statutory payments from the State) to cater for those who may be unable to join contributory schemes. Despite these existing standards, several studies have found that most social security schemes in developing countries are contributory ones, which cover only those in formal employment, leaving most of the population without cover (ISSA, 2019; Nyanguru, 2003; Van Ginneken, 1999).

On the regional level, the African Charter on Human and Peoples' Rights (ACHPR) adopted in 1981 makes special provisions for Older Persons, referring to persons aged 60 years and above based on the United Nations designation. Article 18(4) of the ACHPR states that older persons and people with disabilities shall also have the right to purposeful measures of protection in keeping with their physical and moral needs. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa, adopted on January 31, 2016, contains more far-reaching provisions. Article 7 of the Protocol provides that States Parties shall develop policies and legislation that ensure older persons who retire from their employment are provided with adequate pensions and other forms of social security; to ensure that universal social protection mechanisms exist to provide income security for those older persons who did not have the opportunity to contribute to any social security provisions; to ensure that the processes and procedures of accessing pensions are decentralised, simple and dignified; to take legislative and other measures to enable individuals to prepare for income security in old age; and take legislative and

other measures that facilitate the rights of older persons to access services from state providers.

The Protocol further provides in article 10 that family members who provide care to older persons need to be incentivised by States Parties, and that traditional support systems should be strengthened to enhance the abilities of families and communities to care for older persons. Article 15 of the Protocol also enjoins States Parties to guarantee rights of older persons to health services and to take reasonable measures to facilitate access to medical insurance cover within available resources. On the face of it, these provisions look positive and progressive; however, there are serious doubts about their implementation. For example, even though the Protocol is expected to come into effect with the deposition of the 15th instrument of ratification by States Parties, since its adoption in 2016, only two countries, Benin, and Lesotho, have duly signed, ratified, and deposited their instruments of ratification at the AU Commission, as of October 2019. Ghana signed the Protocol on July 4, 2017, but no further action has been taken on it.

On the domestic level, article 37, clause 2(b) of the Fourth Republican Constitution of Ghana, 1992, provides that the State shall enact appropriate laws to assure the protection and promotion of all other basic human rights and freedoms, including the rights of the disabled, the aged, children and other vulnerable groups in the development process. Consequently, in 2010, the Government of Ghana introduced the *National Ageing Policy: Ageing with Security and Dignity*, with the aim of addressing the needs of the elderly (Ministry of Employment and Social Welfare, 2010). Programmes that have targeted the welfare of the elderly include the National Health Insurance Scheme (NHIS) with provides free medical care for persons 70 years and above, and the Livelihood Empowerment Against Poverty (LEAP),

which partially targets the elderly poor (Hamel & Flowers, 2018). However, significant challenges remain regarding the social security and living conditions of the elderly in Ghana.

Method

The study followed a cross-sectional design to obtain quantitative and qualitative data on the living conditions of the elderly and to investigate the coping mechanisms on which they rely for support. The cross-sectional survey involved participants who were purposively selected based on criteria such as age, gender, educational attainment, occupation, and location (in both rural and urban settlements). The age categories of participants included the young-old (60-74 years) constituting 58.3 percent; middle-old (75-84 years) forming 35.9 percent; and the old-old (85 years and above) made up of 5.8 percent. To obtain empirical evidence from the life experiences of the elderly, primary data was obtained through face-to-face semi-structured interviews involving 211 elderly persons drawn from five adjoining districts in the central region of Ghana, namely, Effutu Municipal Assembly, Agona West Municipal Assembly, Agona East District, Gomoa East District, and Gomoa Central District. Data collection took place from July-September 2019 in the homes or workplaces of participants, with due observance of research ethics principles such as informed and voluntary consent, confidentiality, anonymity of research participants, beneficence or no harm to participants, and reciprocity (Halai, 2006). The question items covered basic demographics, level of education, employment, experience of poverty, coping mechanisms against poverty and income insecurity, awareness of programmes and organisations that support older people, and any other comments they wished to make on the subject. Data was analysed with spreadsheets to obtain information on distributions, trends, key issues, patterns,

and associations. Of the 211 participants, 104 were females constituting 49.3 percent and 107 were males, constituting 50.7 percent and in terms of place of residence, 60.7 percent lived in rural settlements while 39.3 percent lived in urban towns in the selected districts and municipalities.

The follow up qualitative study involved about 30 participants in August 2021, drawn from Agona East, Agona West and Gomoa Central Districts in the Central region. Qualitative interviews focused on the effects of the Covid on health care, social relations, emotional stress, economic activities, and upkeep during the crisis. All Covid protocols were observed during qualitative interviews, and the data obtained was analysed thematically.

RESULTS

Employment and Education

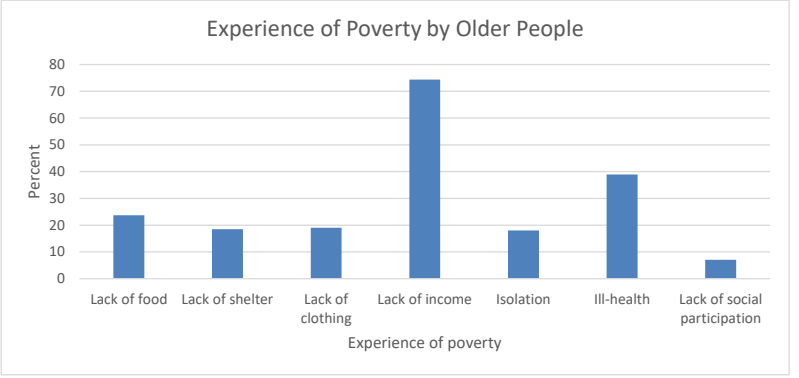
Concerning employment and education, more than 60 percent of the elderly who participated in the study continued to work in old age, with 30 percent involved in agriculture, 31.9 percent in services, whiles 37.6 percent were not working. This was mainly because they were own-account workers and had to continue working to earn a living since they had no pension income. With reference to education, a gendered analysis showed that male participation in education was higher than females, indicating a clear trend that males went further and participated more in education than their female counterparts. For example, of the 211 participants, only 25 males had no schooling in comparison to 47 females in the same situation. Furthermore, 27 males completed junior high school whiles 19 females did same. At the secondary school level, the situation is more telling: 18 males completed senior high, technical, or vocational education whereas only 4 females reported same. At the tertiary level, 12

males fully completed whereas only 2 females attained this level of education. This situation reinforces the need to aggressively promote female participation in education at all levels.

Experience of poverty and ability to meet living expenses

Regarding poverty and ability meet expenses, lack of income emerged as the leading experience of poverty among the elderly. In response to how the elderly experience poverty in a multiple response schedule, the most frequent experience of poverty mentioned by the elderly was lack of income (74.4%); this was followed by ill-health (38.9%), lack of food (23.7%), lack of clothing (19%), lack of shelter (18.5%), isolation (18%) and lack of social participation (7.1%). However, it is important to state these components of poverty mentioned by the elderly do not stand in isolation but are closely related and reinforce each other. Figure 1 below presents an overview of how the elderly or older people experience poverty.

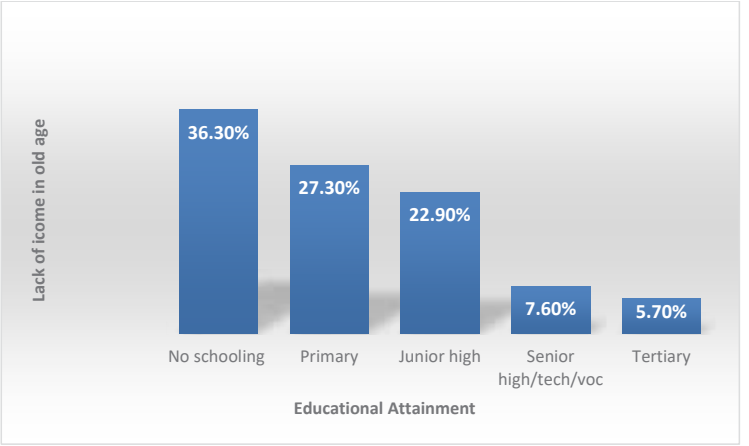
Figure 1: Experience of Poverty by Older People



Source: Author, 2019.

Furthermore, the findings show that higher educational attainment was associated with low-income poverty; conversely, lower educational attainment was associated with higher-income poverty in old age. Income poverty was less among those with higher educational attainment. For example, of those who reported lack of income as an experience of poverty, 36.3 percent had no schooling, 27.3 percent completed primary education, and 22.9 percent completed junior high school. Secondary, technical, and vocational education was the watershed after which point, experience of income poverty dropped into single digit, viz., 7.6 percent for those who completed senior high, technical, or vocational education, and 5.7 percent for those who completed tertiary education. Figure 2 below presents an overview of the finding.

Figure 2: Educational Attainment and Lack of Income in Old Age

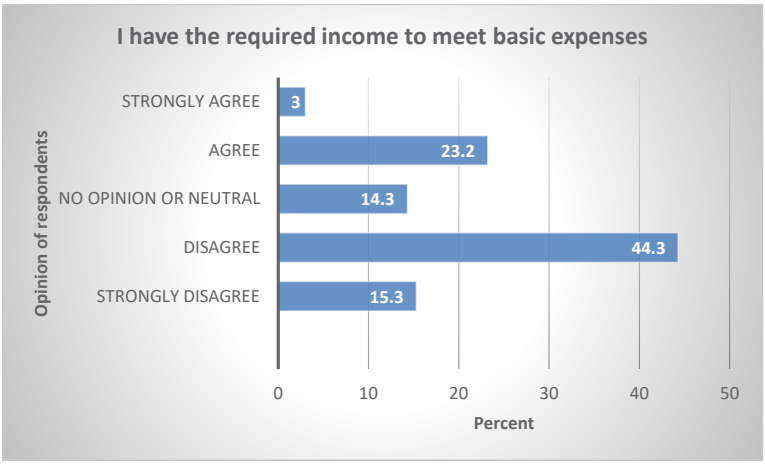


Source: Author, 2019.

Ability to meet basic living expenses remains one of the fundamental requirements to maintain a reasonable standard

of living, but only one in four of the elderly surveyed reported having enough income to meet living expenses. Only 26.2 percent of the elderly either strongly agreed or agreed that they had the required income to meet their basic expenses, with as much as 59.6 percent strongly disagreeing or disagreeing, and 14.3 percent remaining neutral. A gendered analysis of the responses provides further nuance to this finding; 35 percent of male respondents indicated that they strongly agreed or agreed having required income to meet basic expenses, whereas only 18 percent of female elderly respondents indicated same. This points to a disparity in income between the male and female elderly surveyed. Figure 3 below provides a clearer view of the responses by the elderly regarding their ability to meet basic expenses.

Figure 3: Required Income to Meet Basic Expenses

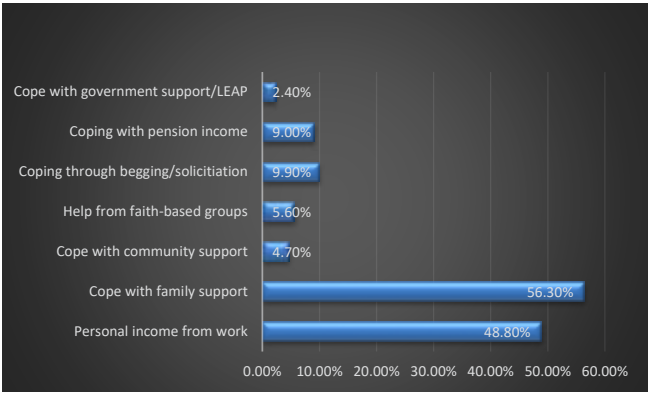


Source: Author, 2019.

Coping mechanisms

Reliance on family support and income from business activities emerged as the top two coping mechanisms against poverty by the elderly. Over 56 percent indicated that they rely on family support, 48.8 percent cope with personal income from the work, 9.9 percent cope through begging or solicitations, 9.0 percent cope with pension income, 5.6 percent cope with help from faith-based groups, and 4.7 percent rely on community support (multiple responses allowed). Only 2.4 percent indicated that they received government support to meet living expenses, through the Livelihood Empowerment Against Poverty (LEAP) programme. This was a striking revelation because the State as a duty-bearer under international, regional, and domestic statutes has greater obligations towards the care of the elderly. However, its role remains negligible from this finding (See Figure 4). Furthermore, a gendered analysis of the finding revealed that male elderly relied more on pensions and income from work to cope with poverty and less on family support, whereas female elderly relied more on family support, and less on pension and income from work.

Figure 4: Coping Mechanisms of Older People



Source: Author, 2019.

The findings also showed that those with limited or no education relied more on family support than those with higher education, who with higher educational attainment who relied more on income from pension. A closer analysis of the elderly who rely on family support as a coping mechanism revealed that more than 96% of them had no schooling, completed only primary or junior high school. Thus, it was observed from the analysis that as the level of educational attainment increased, there was less reliance on family support during old age, but greater reliance on pension income from formal employment.

Other sources of support

Faith-based groups and non-governmental organisations emerged as the next most important sources of support for the elderly. Faith-based groups were mentioned by 5.7 percent of respondents as a source of support, and they included Church of Pentecost, Anglican Church, Seventh-Day Adventist Church, International Central Gospel Church, Jehovah Witnesses, Islamic Faith groups, and Latter-Day Saints. These were mostly involved in providing small loans, farming materials to the elderly who participated in farming or other economic activities. The USAID provided free healthcare screening and free registration for elderly people, including payment of NHIS re-activation and subscription fees, especially for those less than 70 years of age and therefore did not qualify for free health care under the NHIS. Plan Ghana was also involved in providing money to pay educational expenses of children and grandchildren that live with the elderly to cater for uniforms, books, and materials, where government supplies fail or were inadequate. CAMFED was also involved in sponsoring brilliant but needy girls living with the elderly through their education by ensuring that they had everything needed to complete successfully. The findings

showed that 4.3 percent of the respondents received support from non-governmental organisations. Community-based organisations provided care for the sick elderly, small loans to support economic activities of the elderly, and support for orphans living with the elderly; 2.4 percent of respondents reported receiving help from such organisations.

Effect of Covid-19 pandemic on the aged

Qualitative interviews conducted in August 2021 to investigate the challenges faced by the aged during the Covid-19 pandemic show that the Covid indeed affected the aged with reference to health, social relations, emotionally and economically.

With reference to health, some of the aged reported in interviews that they have blood pressure problems, so the wearing nose mask is difficult for them, and having to wear it constantly frightens them sometimes (female, 60yrs, 19/08/2021; male, 71yrs, 17/08/2021). Some having difficulty in breathing when they wear the nose mask at their age but have no choice but to wear it to protect themselves against the Covid (female, 82yrs, 19/08/2021). Some of the aged reported not being able to go to the hospital often for regular check-ups because they feared contracting the virus or other infections from the hospitals, since they were no longer safe places (male, 75yrs, 17/08/2021; female, 63yrs, 17/08/2021). Others complained of having to inhale the same air they breathed out,which made them uncomfortable and sick sometimes (female, 72yrs, 17/08/2021).

Social relations of the aged appears to have been affected seriously during the Covid, and the respondents expressed these in many ways during interviews when commenting on the subject. Their comments include the following:

Oh yes! Since there were a lots of restriction social gathering, I found it difficult to relate with friends and loved once. Some of us our daily routines is home to church and home to market and this was disrupted by the pandemic (female, 78yrs, 17/08/2021).

I wasn't able to relate with my friends because we were scared of contracting the virus (female, 75yrs, 2021)

Yes, because as a chief I have to protect myself and my people. All activities like our festivals are put on hold. My sub-chiefs and elders cannot visit me at the palace for us to think about our community (chief, 70yrs, 18/08/2021).

I could not meet my own children after they returned from abroad, and they had to be quarantined for almost two weeks (male, 75yrs, 17/08/2021).

The constant wearing of nose mask gave people new identity, making it difficult to see my own friends (male, 61yrs, 17/08/2021)

I was quarantined which made my friends scared of coming close to me (male, 64yrs, 19/08/2021)

I could not attend the annual family re-union and also as an Ebusuapanyin (head of clan), but we could not have our normal family meetings (head of clan, 75yrs, 17/08/2021).

On a brighter note, the pandemic brought some relatives home from overseas since they felt Ghana was safer as compared to where they were living abroad (female, 61yrs, 17/08/2021). The lockdown also made it possible for the aged to spend more time with grandchildren and were happy for their company (female, 61yrs, 1708/2021).

Many of the aged were also affected emotionally by the pandemic because much of the information shared with the public indicated that they were most at risk. The daily updates also evoked much fear among them, as revealed in the following excerpts:

> *Yes, imagine you are being told the chance to get the virus is high due to your age. It kept me thinking. The fear that the normal allergies can mean you might have the virus was even disturbing (female, 75yrs, 18/08/2021).*
>
> *The daily news update made me scared for my children in the city (female, 80yrs, 19/08/2021).*
>
> *It has brought fear on us. You can't even go out to do what you want to do (male, 65yrs, 18/08/2021).*
>
> *How they report the news is scary and I always get scared going out. I didn't get any personal education on the covid, so the news got me scared (male, 70yrs, 18/08/2021).*
>
> *The normal symptoms of malaria were likened to the symptoms of COVID and this put me fear in me especially when I was not feeling well (male, 61yrs, 17/08/2021).*
>
> *Those who educated us made us feel that coughing was the main symptoms, so I was scared when anyone close to me coughed constantly (female, 60yrs, 17/08/2021).*
>
> *The very few people who wore the nose mask were nicknamed and this infuriated me at times (female, 75yrs, 17/08/2021).*

Economic activities and upkeep during the pandemic

In relation to economic activities and access to food, water, shelter, clothing, and electricity, many of the aged respondents indicated that life was not easy for them because everything

came to a standstill and the cost of living increased for them due to low production food and basic items (male, 80yrs, 18/08/2021). Some respondents indicated that people hardly contracted them for work, and as a result, things were difficult for those who must work in old age and depend on their own resources (male, 62yrs, 18/08/2021). Others who were not working but depended on their children faced economic challenges because the children who provided for them were also out of work due to the pandemic (female, 61yrs, 18/08/2021). The lockdown prevented some from going to the market to trade and make a living (female, 72yrs, 17/08/2021), and some respondents who were farmers could not send their farm produce to the market (male, 61yrs, 17/08/2021). However, the living costs of the aged went up because all the grandchildren and children had come home and they spent more money feeding all of them (female, 61yrs, 17/08/2021).

When asked about what could be done to support the care of older persons in this pandemic and beyond, some of the aged indicated that those who are on pension depend on their pension pay for support, but the most difficult problem lies on those who are not on any pension at all, and they think government or community leaders can support to take care of the aged (female, 74yrs, 19/08/2021). They argued that old age is part of our life, and the government must make it a point to assist the aged (chief, 70yrs, 18/08/2021). Some also proposed that community health personal should constantly visit the aged and educate them about their health issues (female, 72yrs, 17/08/2021).

DISCUSSION

The elderly, social security and obligations of the state

Government support to the elderly identified in this study were through the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme (NHIS). However, only 5 participants representing 2.4 percent indicated that they received income support from the LEAP programme. Regarding the NHIS which provided free registration for the elderly 70 years and above, 47.4 percent of the respondents indicated that they received health care support from the scheme. Even though as much as 66.3 percent of the respondents were aware of programmes that supported the elderly, such as the LEAP and NHIS, only 38.9 percent reported benefiting from these, mostly the NHIS.

Several key findings stand out for consideration from this study. First, lack of adequate income emerged as the main experience of poverty reported by 74.4 percent of the elderly, and this was related to lack of coverage by any formal pension scheme. Indeed, only 9 percent of the respondents reported receiving pension, leaving 91 percent without pension income. Subsequently, only 1 in 4 of the elderly surveyed (26.2%) reported having the required income to meet their basic living expenses. This finding corroborates earlier studies which reported that pension coverage in developing countries range between 10-25 percent, and in Africa, over 90 percent of the population has no pension coverage (Van Ginneken, 1999). The study by Yanguru (2003) in Lesotho also found that between 50-70 percent of the elderly were not covered by pensions. International statutory provisions on social security for the elderly such as ILO Convention 102 (1952) stipulates that social security must provide income to guarantee a reasonable standard of living during old age. However, the

findings of this study stand in sharp contrast to the provisions of the convention.

The second key finding is that higher educational attainment is associated with less income poverty in old age. The findings show that experience of income poverty drops by 9 percentage points after completion of primary schooling and by 4.4 percentage points after completion of junior high school. The biggest drop of 15.3 percentage points occurs after completion of senior high, technical, or vocational school. This remains a very instructive finding in relation to the promotion of secondary, technical, and vocational education.

A third finding, related to education was that higher educational attainment was associated with increased likelihood to be on a formal pension scheme, and less dependence on family for support. This was mainly because higher educational attainment increased the likelihood to be employed in the formal sector, and thereby, to be on a formal pension scheme. Thus, promoting higher educational attainment could lead to expansion of social security coverage for more persons, which confirms similar findings by Elstada et al. (2019) in Nordic Welfare States, that the elderly with higher education tend to have more income or more favourable social security at retirement.

The fourth finding concerned intersecting experiences of poverty among the elderly. The experiences of poverty reported by the elderly included lack of adequate income, ill-health, lack of food, clothing, shelter, isolation, and lack of social participation. These were found to be reinforcing and not mutually exclusive. This pointed to the lack of provision to meet multiple human needs such as physical and psychological health, including food, shelter, social participation, and self-esteem discussed by Dean (2010). Thus, tackling poverty effectively among the elderly would have to take these multiple dimensions into account.

The next most important finding is that there is still heavy dependence on family relations and income from work as a coping mechanism by the elderly surveyed. The family emerged as the first line of support especially for those with limited or no education but was less important in same respect for the elderly with higher educational attainment. An earlier study by Kpessa-Whyte (2018) found a weakening of the family as source of support in old age. However, the finding in this study indicates that the family remains an avenue or refuge for the elderly who fall into challenging times, reinforcing the position of Kumado and Gockel (2003) on the importance of the extended family in the Ghanaian society. Article 10 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa (2016) enjoins State Parties to incentivise family members who provide care for the elderly and to strengthen traditional support systems and abilities of families and communities to care for the elderly. However, not much has happened in this regard in view of findings from this study.

Fundamentally, the findings of the study indicate that the support of the State to the elderly as a statutory duty bearer under international, regional, and domestic legislation has been very negligible. Not much has changed during the Covid-19 pandemic. Only 2.4 percent of the elderly surveyed reported receiving any income support from the State, and this was under the Livelihood Empowerment Against Poverty (LEAP) programme. Faith-based groups (5.7%) and non-governmental organisations (4.3%) were doing much better than the State, in supporting the livelihood of the elderly. However, Article 22 of the Universal Declaration of Human Rights (UDHR), to which Ghana is a signatory, states that every member of society, including the elderly, has a right to social security. Article 25 of the same UDHR states that everyone, including a person in old age, has the right to a standard of living that is adequate for their

health and well-being, including food, clothing, housing, and medical care. Article 37, clause 2(b) of the 1992 Constitution of the Republic of Ghana, enjoins the State to pass legislation to ensure social security as a basic right for specifically named persons such as the aged. However, apart from the health coverage of the elderly 70 years and above, and coverage given to the elderly poor under the LEAP, a vast majority of the elderly are struggling to survive, at least, according to the findings of this study. The State as a statutory duty-bearer remains virtually absent in the care of the elderly, despite international, regional, and domestic obligations in this regard. However, it is recognised here that further studies would be required to examine the full extent and depth of these findings.

Conclusion

Based on the findings of the study, the following conclusions have been drawn. Majority of the elderly surveyed were struggling to maintain a reasonable standard of living, with as much as 74.4 percent of them experiencing income poverty, followed by experience of ill-health and lack of food, which intersect and were not mutually exclusive. Indeed, only about 1 in 4 of the elderly surveyed reported that they had adequate income to meet their basic living expenses. However, it was also found that higher educational attainment was associated with reduction in income poverty, and that the biggest drop in income poverty occurs after completion of senior high, technical, or vocational education. About coping mechanisms, the elderly cope with poverty through reliance on family relations for support. However, the elderly with higher educational attainment relied less on family support in comparison to those with limited or no education. More than 60 percent of the elderly continue to work after age 60, with some continuing into their eighties to earn income to cater for their needs. Apart from family and income from work,

faith-based organisations and non-governmental organisations emerged as the most important sources of support for the care of the elderly.

The obligations of the State as a duty bearer to ensure a reasonable standard of living for the aged remains unfulfilled. Indeed, only 2.4 percent of the elderly surveyed reported receiving such support from the State under the Livelihood Empowerment Against Poverty (LEAP) programme. Faith-based organisations (5.7%) and non-governmental organisations (4.3%) performed better than the State in this regard. However, 47.4 percent of the elderly reported receiving healthcare support under the National Health Insurance Scheme (NHIS), which gives free coverage for those 70 years and above. Aside these provisions under NHIS and LEAP, the State as a duty bearer under international, regional, and domestic legislation is absent regarding the care of the elderly. It is therefore the position of this paper that the State has not lived up to its obligations towards the care of the elderly under statutory commitments it has made. On the bases of these conclusions, it is recommended that a statutory, guaranteed, non-contributory social security scheme be established to ensure a reasonable standard of living for the elderly. However, further studies may be needed to examine the extent and depth of elderly poverty and their coping mechanisms to respond effectively.

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Efficacy of Dance Movement on the Wellbeing of the Elderly in Ghana

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Abstract

In Ghana, one major contributing factor to the poor wellbeing of the aged is associated with inactivity and sedentary lifestyle. As seniors age, the rate at which they engage in physical activity decreases. This makes their inactive bodies prone to diseases such as muscle mass reduction, osteoporosis, and poor balancing, less mobility endurance, flexibility, and general loss of wellbeing. Meanwhile the aging populace forms a crucial part of Ghana's human resource base, thus, the need to safeguard their pre- and post-retirement health. Currently, the application of dance movement technique as a physical wellness and fitness activity in improving the wellbeing of the elderly in Ghana is under explored. This was an exploratory case study which set out to examine the efficacy of dance movement in improving the general wellbeing of the elderly in Ghana. The triangulation method design was adopted to collect data from 20 participants (male and female) who enrolled into the dance for fitness program organized by Centre for Aging Studies (CFAS) in collaboration with the Department of Dance Studies at the University of Ghana Legon. Each participant's systolic and diastolic blood pressure levels were recorded before and after each session and questionnaires administered through series of weekly interviews. Other instruments such as observation of the participants, video recording of the sessions, and face-to-face interviews were also used to ascertain the efficacy of dance movement on the general wellbeing of the seniors. The study

indicates that the aged or seniors in Ghana desire to engage in dance as soma-physical activity to prevent and/or reduce some age-related diseases and to improve their general wellbeing.

The findings suggest that helping seniors make the right choice towards healthy and successful ageing goes a long way to helping them age gracefully. This is because successful ageing is a socioeconomic need. Therefore, using dance movement technique as a preventive tool for improving the wellbeing of the elderly within our society is likely to minimize the high cost of medical care for the aged. Again, the application of soma-wellness and its knowledge has the tendency to decongest and ease the pressure on our ill-equipped hospitals and other health facilities especially in this COVID- 19 era.

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Introduction

Globally, the population of the elderly is rapidly increasing. It is estimated that the number of people aged from 60 years and above will rise to 2 billion by the year 2050 (WHO, 2014).]. In Ghana for example, the population of the elderly (ages 60 years and above) is expected to double from its current state of 6.7% of the national population to more than 12% by the year 2050 (WHO, 2014). Currently, the age structure of Ghana's population is gradually changing in line with the global pattern. This can be attributed to the decline in mortality and fertility rates and an increase in life expectancy, from advancement in medical technology and improved living standards this increase is likely to put pressure on the already scarce health infrastructure in the country.

What this invariably means is that there is no end to this increase. According to the Ghana Statistical Service (2010) the "... elderly refers to a category of adults who have attained advanced ages, 60 or 65 years" (p. iii). And an individual is said to be "...ageing when he/she attains ages that are classified as old ages" (p. III). In contrast, this study considers the aged as persons from age 50 and above. Demographically, the aged or seniors is used to refer to persons within the age bracket of 60 to 65 years. However, this age bracket varies in both developed and the developing world. In Ghana for example, the formal sector considers the retirement age to be 60 years and people are considered elderly once they retire.

Weeks (2012) divides the aged into "young old", and the "old old" based on their disparity, relative strength, agility, and the zeal to perform physical activities like dancing, and walking. He further categorizes the "young old" as those within the age bracket of 65-74 and the "old old" as those from 75 – 90.

In a personal communication with one of the participants of this study, she said "I … see ageing as a state of mind, as I sit here, I'm 60 years but I see myself as young and not old". To a person like this the idea of "young old" might not work for her. In fact, linear age does not relate perfectly with functional age. For instance, two people may be of the same age, but differ in their mental and physical capacities (Bowen & Atwood, 2004).

However, because the definition restricts the age limit to 60 (in the case of Ghana), policies that affect "oldest old" affect the active "young old" too. Given the Ghanaian cultural system and role assignments, persons beyond the age of 60 are still engaged in both productive and reproductive caregiving activities such as heads of their homes, bathing of new-born babies in their communities, and attending to delivery of children (GSS, 2013). There are more female aged people (56%) as compared to male (44%). This is

one of the features of global ageing (GSS, 2013). About 58.5% of the elderly populace are economically active in formal or self-employed like agriculture (63.1%), sales work (13.3%), or craft and related trade (8.4%) (GSS, 2013). These occupations serve as major source of employment for the elderly, and about 84.4 % engage in these activities. However, just 2.7% of these aged are professionals. They serve in jobs as managers, technicians, and professionals. This shows that majority of the elderly are engaged in low-income employment. This kind of gap has the potential of increasing the vulnerability of the elderly as they age. Because most of these jobs demand for physical, mental, and emotional strength and commitment which declines as one ages. The physicality of their ageing becomes evident with the onset of wrinkles on their facial muscles, coupled with mobility problems, so some tend to use walking sticks. Eventually, when those who interact with the elderly stereotype them by infantilizing them, it leads to low self-esteem which affects them emotionally in a negative way (Yasmaski, 2009). This tends to create fear, anxiety, stress, depression, and other negative health problems for them. Aside all these, there are equally some factors that contribute to ageing which have adverse effect on the body, mind, and spirit of the elderly. The presence of chronic disease amongst the elderly in Ghana is very alarming and the most common ones includes cardiovascular diseases, cancers, respiratory diseases, arthritis, and other infectious diseases including chronic malnutrition, anaemia, osteoporosis, and hearing and sight problems.

In summary the causes of these chronic conditions range from poor lifestyle choices, genetic and environmental factors, and all these conditions negatively impact the general wellbeing of the elderly in Ghana. With the upsurge of chronic diseases, the healthcare system in Ghana is ill equipped in terms of infrastructure and specialized personnel for meeting the health

care needs of the older population (Open Access, 2017). This makes preventive care for the elderly an indispensable tool.

Wellness as a lifestyle

The idea of wellness for the aged is intricate due to its multifaceted nature. It includes life values and fulfilment, self-esteem, and contentment. Therefore, the definition of the welfare and contentment of the aged, to a large extent relies on their affective and cognitive experiences. The affective aspect comprises of optimistic and pessimistic sentiments, and moods, whereas the cognitive facet has to do with the individual's subjective notion of life as compared to an idyllic hope of fulfilling their desires and aspirations (Alaphilippe & Bailly, 2014).

The concept of wellness is more than being physically fit, it is a holistic phenomenon that encourages a lifestyle that helps to improve and enhance the body, mind, and spirit. This holistic philosophy of wellness is inclined to dance. Similarly, the holistic nature of dance has a bearing on the body, mind, and spirit. Hence, there is the need to make this phenomenon accessible and appreciated by the elderly as an alternative medium for improving their general wellbeing as they age.

Moreover, most research findings have proven that the elderly who embrace the concept of wellness as part of their daily life activities have reaped a lot of health benefits from it. Thus, the health benefit of dance movement as a medium of wellness and health, has been elucidated by many scholars (Balgaonkar, 2010; Hanna, 2006) amongst others. For instance, in a non-pathological populace, the barometer for wellbeing is not co-terminus with age. Though the individual's current condition of life can influence his/her wellbeing to an extent, those conditions do not play a key role in that determination. These conditions can be subjective

or objective. Hence, the need to distinguish between objective wellbeing determinant conditions such as state of health, wealth status, and social networks of support as against the subjective aspect that deals with how a person measures himself or herself based on his/her health, financial standing, or social networks of support (Alaphilippe & et al., 2013).

They concluded that, though objective pointers like health plays a key role in evaluating what successful ageing is, subjective indicators like the individual's perception of his/her wellness condition equally matters. The definition and value of successful ageing as a concept, therefore, draws largely from how it impacts on the objective or subjective condition of the individual.

It is important to explore the historical underpinnings of dance as movement therapy. Dance Movement Therapy promotes security for the elderly through some methodologies such as providing choices (what movements do I like? Where do I feel comfortable?); promotes self-awareness; focusing on movement resources decreases feelings of insufficiency; walking in various manners provides security; sensory stimulation of the feet promotes stability; light or strong movements and light music vitalize; moving means to collect joy (p. 146). The above quotation captures in its entirety the essence of this study. That is to explore all the movements mentioned in tackling the wellbeing of the elderly.

Dance as a somatic practice aims to assimilate mind and body of the elderly in a rebuttal against cartesian dualism theory, which states that, what affects the mind does not necessarily affect the body and vice versa. It establishes a connection between one's emotion and feelings. (Damásio, 2012; Levy, 2005). The primary outlet for emotions is the body, which expresses movement. Hence, one can use the movement as a medium for working on

the emotional wellbeing of the participants. Dance movement technique can be used to help participants unburden their pent-up emotions because it is in the handling of these emotions that we find the meaning to our existence positively. Furthermore, it is important to realize that the individual can learn to harness, control, and be creative about how he/she responds to his/her inner self talk using the arts (dance) (Noble, n.d.).

Benefits of dance movement as a physical wellness medium for the elderly

Rose (2008), as quoted in Baptista, J.R., and Narciso (2015) posits that "physical exercise in elderly people is effective in reducing physical risk factors normally associated with the high risk of falls" (p. 71). Dancing as a physical form of wellness has advantages on the general wellbeing of the elderly. Cammany (2005) states that dance movement helps in stimulating the lungs, cardiovascular and the musculoskeletal. It also activates the mind, thereby averting falls and favoring coordination, spatial orientation, and balance. Lack of balance and coordination are factors that often cause a fall among the elderly (Eyigor et al., 2009). Connolly and Redding (2010) reported that falls that lead to stroke are a major cause of hurt, fear, increased anxiety, and demise amongst the elderly.

Studies were conducted geared towards creating programs and interventions to aid the elderly to age successfully. In one of the studies, Connolly, and Redding (2010) conclude that there was improvement in the balance and stability posture of individuals with Parkinson's disease because of their participation in dance movement techniques. Clearly, this falls within the context of the objective of this study which seeks to examine the efficacy of dance movement on the wellbeing of the elderly in Ghana.

Also, Eyigor et al. (2009), buttressed the view that physical enhancement leading to stability and quality of life are vital to the wellbeing of the elderly because it helps to increase or maintain their autonomy.

Borges and Colleagues (2014) postulates that, those institutionalized aged who have been housed for a long time, tend to exhibit some level of sedentary lifestyle. However, by participating in ballroom dancing their balancing level improved, thus, reducing the risk of fall and increased their physical wellbeing. Similarly, Rose (2008) and McKinley and Colleagues (2008) also share the opinion that, imploring Tango dance from Argentina as a wellness tool for the elderly helps improve their wellbeing and physical outlooks, which in effect can reduce the risk of falls. The use of dance as a medium for improving well-being appears to be a core fundamental tool for promoting physiological, mental, social, emotional and psychotherapeutic work with the elderly. Dance '*somaticism' a*s I call it, dwells more on experiencing the body from an inside perspective to the outside. '*Somaticism'* deals with body awareness. This concept helps a person's physical, physiological, mental, communal mixing. All these elements help provide optimal well-being for the elderly.

Concept of active ageing

The idea of active ageing emanated from a 2002 World Health Organisation vision document on life-long learning. Active ageing refers to the process of enhancing prospects for quality of life as people age based on a foundation of wellbeing participation and safety. The elderly need to be treated with care and dignity as against the passive care they receive. Therefore, active ageing refers to the participation of the elderly in socio-economic and other activities (Almeida, 2007; Osorio, 2007;

WHO, 2002). For this concept of active ageing to stand the test of time, care providers must include wellness, as well as the physical environment the aged live in to minimize age-related diseases. Thus, "active ageing depends on a set of influences at the level of the individual, the family support network and of society in general (Direcção Geral de Saúde [DGS], 2008)."

Method

The sole intent of the study is to examine the efficacy of dance movement practice as a holistic non-medicinal approach in improving the general wellbeing of the elderly in contemporary Ghana. This study implores the exploratory case study design with the mixed methods approach in practice-based research. The case study of some elderly participants who enrolled on the dance for fitness program organized by Centre for Aging Studies in collaboration with the Department of Dance Studies at the University of Ghana, Legon, were used for the research.

Twenty (20) elderly male and female participants between the ages of 50 and 70 years took part in this study. The participants were subjectively chosen based on their availability, willingness, readiness, and participation in the project to share their knowledge and experiences on how the dance movement technique has affected their wellbeing. They were divided into two groups; focus group and the experimental group they were taken through dance movement technique for a period of sixteen (16) weeks with the purpose of ascertaining the impact of the dance movements on their wellbeing.

The data sources for this study were grouped into primary and secondary data. The secondary data for this study was collected from book sources, journal sources, and published and unpublished materials that are relevant to this study. The primary

data was collected from the elderly within the ages of 50 years to 80 years who participated in the dance for fitness program through interviews, questionnaires, focus group discussions, participatory approach, in-depth interviews, and participant observation with other quantitative approaches such as a pre-test and post-test survey, and recording of their systolic and diastolic blood pressures and pulse. Some series of interviews were also conducted before the beginning of the project, mid-section and at the end to ascertain the efficacy of the dance movement on their general wellbeing test and strata 13 version which is more statistical shall be run for test result at the end of the session.

Throughout the sixteen (16) weeks period of the dance movements practice for improving wellbeing, the systolic and diastolic blood pressure (SBP & DBP) and pulse levels of participant were recorded before and after each session for quantitative data analysis purposes. The approach was used to collate participant's pre and post blood and pulse data for each session. Importantly, the participants were also mostly advised to visit the hospital intermittently for general checkups and to minimize the kind of movements they make due to their age.

Data analysis technique

The data gathered from the study were in both qualitative and quantitative types. Therefore, both qualitative and quantitative analytical techniques were adopted. Concerning the qualitative data, a content analytical technique was used. The quantitative data was analyzed using statistical techniques in Stata version 13. Particularly, regression analysis functions were used. This was to examine the effectiveness of the dance movements on the systolic and diastolic blood pressures of the participants and on their general wellbeing by identifying the level of changes with

their blood pressure and their responses as they engaged in the activity. Strata version 13 was used in representing frequency graphs to improve the analysis of the data.

The collation of the quantitative primary data was done through a comparison of the before and after blood pressure readings of the participants. This was to ascertain the effectiveness of dance movement technique as a holistic form of wellness. In all, the triangulation of methods proposed a rich data source and the opportunity to corroborate findings across the methods (Wellington, 2015).

Demographics of respondents

This section outlines the background characteristics of the 20 participants sampled for the intervention. Their background characteristics includes sex, age, education, marital status, and occupation. As part of the background checks, the study also investigated the state of the participants' welfare issues including their physical, medical condition, and blood pressure prior to the intervention of the DMP project.

Table 1: Respondents' Background Profile

Variables	Gender		
Age	Male	Female	Total
50 – 59	1 (5.2%)	3 (15.8%)	4 (21.0%)
60 – 69	-	6(31.6%)	6(31.6%)
70 – 79	4 (21.1%)	5(26.3%)	9 (47.4%)
Total	5 (26.3%)	14 (73.7%)	19 (100%)

Education	Male	Female	Total
College	-	3(15.79%)	3(15.79%)
Bachelor	2(10.53%)	3(15.79%)	5(26.32%)
Masters	2(10.53%)	6(31.58%)	8(42.11%)
PhD	1(5.26 %)	2(10.53%)	3(15.79%)
Total	**5(26.32%**	**14(73.68%)**	**19 (100%)**
Marital Status			
Single	-	3(15%)	3(15%)
Married	2(10%)	7(35%)	9(45%)
Divorced	2(10%)	3(15%)	5(25%)
Widowed	1(5%)	1(5%)	2(10%)
Separated	-	1(5%)	1(5%)
Total	**5(25%)**	**15(75%)**	**20(100%)**
Professional Career/Occupation			
Architect	-	1 (5.88%)	1 (5.88%)
Communication	1 (5.88%)	-	1 (5.88%)
Consultant	-	2(11.76%)	2(11.76%)
Professor	1 (5.88%)	2(11.76%)	3(17.65%)
Educator	-	1 (5.88%)	1 (5.88%)
Engineer and Entrepreneur	1 (5.88%)	-	1 (5.88%)
Lecturer	-	3(17.65%)	3(17.65%)
Nurse	-	3(17.65%)	3(17.65%)
Pensioner	-	1 (5.88%)	1 (5.88%)
Public Servant	-	1 (5.88%)	1 (5.88%)
Total	**3 (17.65%)**	**14 (82.35%)**	**17 (100%)**

Concerning gender, the field data indicated that female elderly participants (25, representing 75%) in the study surpassed the males (5, representing 25%). Perhaps, it was due to selection problem. In terms of age, three categories emerged: 50 – 59, 60 – 69, and 70 – 79. This shows that those within the last category (70 – 79) were more (47.4%) than the others. Again, the females (31.6%) were found to be within the 60 – 69 age brackets. Only one person did not disclose his/her age. Regarding marital status, the respondents (45%) were married couples with just one participant (5%) who had separated. The education results also showed that, majority (42.11%) of the respondents had 'masters' degree qualification. This is not surprising, as all had tertiary education. Owing to their academic qualification, all the respondents had a professional careers, which ranges from professorship to public servants as shown in Table 1 above.

Table 2 below offers a detailed description of the respondents' background information. The respondents' physical activeness, state of health, emotional balance, and social skills were all recorded before they were enrolled onto the project. This was to enable the study to draw a vivid distinction of the achievement of the intervention after its implementation.

Table 2: Medication Condition

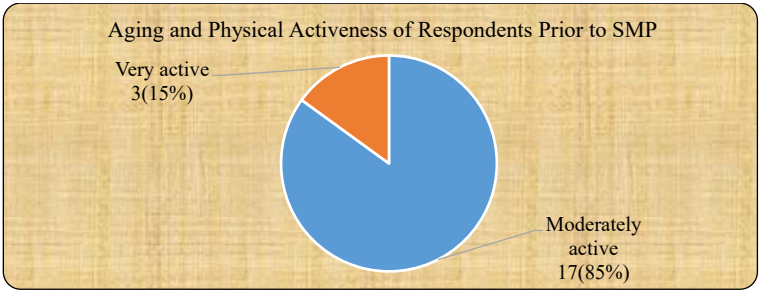
Medication	Male	Female	Total
Yes	1 (5%)	4 (20%)	5 (25%)
No	4 (20%)	11 (55%)	15 (75%)
Total	5 (25%)	15 (75%)	20 (100%)

Source: Researcher's Construct

About (50%) of the participants suffered from both asthma and high cholesterol. Most of the participants have been battling these ailments for years ranging from three (3), five (5) years, fifteen (15), and others over thirty (30) years. However, they were assured that engaging in dance as preventive care intervention medium was not going to affect their wellbeing in a negative way.

In determining their state of wellness before the intervention, the researcher strived to identify how their ageing is affecting their daily physical activities. ***Figure 1*** below outlines the outcome.

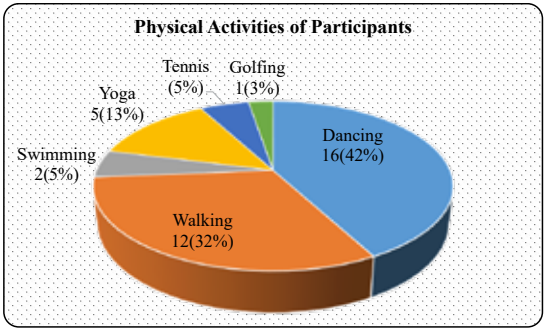
Fig. 1: Response to Ageing and Physical Activeness



Source: Researcher's Construct

As seen in *Figure 1* above, the majority (85%) of the respondents claimed their ageing has made them moderately active. This meant that most of them could engage themselves in physical activities including exercise and other manual actions that demanded efforts. Knowing this, they were asked to mention some of the physical activities they engage in. ***Figure 2*** below outlines the various activities they engage in.

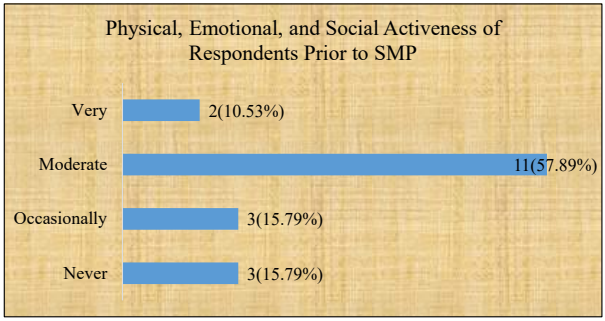
Fig. 2: Respondents' Physical Activities



Source: Researcher's Construct

The results in Figure 2 above show that dancing (42%) and walking (32%) are what most of the elderly do as an activity to maintain their physical wellness and improve their general wellbeing. Other physical activities included yoga, swimming, playing golf, and tennis. Though such physical exercises were being practiced by some respondents, such activities contributed minimally to their entire wellbeing as most (57.89%) claimed their physical, emotional, and social activeness were moderate (*see Figure 3*).

Fig. 3: Respondents' Physical State



Source: Researcher's Construct

From *Figure 3*, only a few (10.5%) were very active in their emotional, social, and physical states. With others, 15.8% were never active and occasionally active, respectively.

Dance Movement Practice (DMP) is an effective holistic wellness and fitness tool. It can improve body sensory awareness, balance, coordination, concentration, and mobility amongst the elderly. This was evident in the interviews conducted after the study period with participants. Most of the participants affirmed that the dance movements helped to improve their coordination, concentration, and mobility drastically. For instance, a participant with the initials AG who is aged 56 years acknowledged that if:

> *"I focus on my body when learning new movements – e.g., how the feet and hands move - then after a while learn to do the movements without thinking about them."*

What this means is that the dance movement techniques used helped the participant in terms of his coordination, concentration, and mobility. This finding is in congruence with McAuley and Katula (1998), McAuley and Rudolph's (1995) assertion that engaging in exercise or dance as a physical activity does not only influence one's wellbeing and physical abilities but also improves the physical functions of the participants. Therefore, DMP when used well, enhances the body's coordination, mobility, and concentration levels.

Body posture stability and physical activeness

Furthermore, the intervention was a tool for improving body posture. One participant said,

> *…because of my sedentary lifestyle I developed some shoulder and back pain, around the age of 50 years. I couldn't lie down so I went to the hospital and was given*

paracetamol and other painkillers, I was advised to engage in physical activity like dance, so I joined this program with these aches, but the shoulders the first time we had the dance movement session with the focus on the shoulder movements, I didn't feel the pain in the shoulder again after I went home and the hip pain is no more, so I can confidently say I got those healing directly through dance movements." (MK, age: 56years)

Image 1: Dance Movement Technique
Source: Author's exploration.

Physical/body mobility and activeness

In terms of active physical mobility, participants expressed their gains enthusiastically. According to one:

> *'It is the best thing I ever did...walking through that door that day because it has improved my mobility so much'* (MM, age: 70years.)

Another two added the following:

> *I think the exercising has been the main benefit, because I have certainly improved my mobility and balance since I have been coming,*' (YB, age: 60 years) and "*My mobility has improved drastically, I feel more relieved in my body through participating in these activities*" (EP age: 70 years).

> *Yes, physical I will say very active, although it comes with pains, but it has improved. There were certain things I couldn't do, but now I see improvement, now I can stop, now I can go down without holding anything thanks to these activities*. (GO age: 77years).

The above quotes also confirm the efficacy of dance movement technique as a preventive care medium for improving the general wellbeing of the elderly in Ghana. Again, engaging in Dance movement technique (DMT) as a preventive care intervention also improves mental stimulation, improves memory, positive social connections, and increased activeness. The DMP drew direct attention to specific sensory aspect of participants' body actions and movements that frequently occur but rarely noticed from inner experience. For example, one of the respondents disclosed that:

> '*It's making us work, it's making us think'* (AAL, age: 60 years). Another exclaimed, "*It helps with my clarity memory, reasoning and thought process"* (OH, age: 58).

One participant gave a more detailed explanation as articulated below.

> *These activities sharpen the brains, especially the dance movements. It makes me smart because at a point in time I feel that if I don't use the brain, I can't get the movement, they sharpen the thinking faculty. It makes you smart and*

> *helps you synchronize the brain and the body.* MM, age: 70years.

In terms of cognitive wellness, a participant explained that:

> *"Cognitively, yes it has improved although I can't measure it, but on an average balance I think I have improved, because at this age when you set up to do something you forget, but now it has improved, these activities have helped to offload some of the stress on my brain."*
> (GO, age: 70 years).

However, it is not merely an aspect of brainwork but for one participant the dance movement practice highlighted her physical challenges that she rarely noticed as a new inner phenomenon. The statement below is her opinion:

> *It's made me aware of how much more difficult it is to pick things up and I hadn't realized that I had slowed down that much but I can see it now and it's made me realize that my reactions are much slower.* (YB, age: 65 years).

Emotional Stability/Wellness

Emotionally, respondents expressed positive impact of the DMT in their lives. Some respondents claimed:

> "*I'm emotionally stable because I don't have time to think about other things that worry me and I'm very active in other things,*" (OK, age: 56 years).

Another respondent added that, '*Emotionally stable yes, because it takes me out of the house and the fact that I look forward to those days and come to a place where I can meet my peers and laugh at each other in our confusions and have fun it has improved my emotional wellbeing*.' (GO, age: 77 years).

Just as the World Health Organization (W.H.O) posits, total welfare for the elderly encompasses emotional, physical, spiritual, intellectual, psychological, and social wellness. This emphasizes the essence of dance movement as a wellness tool to improve the wellbeing of the elderly.

> "*My wellbeing level has improved due to having 3 set days for active dancing and stretching,"* (FM, age: 70years, YB, age: 65years, & AAL, age: 60years).

Image 2: Participants relaxing after the day's session.

DMP is efficacious as a non-pathological means of wellness and has prospects for being fused into the gerontological health system because it is a holistic medium for improving one's general wellbeing. According to the World Health Organization's standards, the total welfare of the elderly consists of emotional, physical, spiritual, intellectual, psychological, and social wellness. This emphasizes the essence of dance movement in somatic practice as an effective wellness tool.

DMP has also contributed to lessening the financial burden associated with medications for age-related diseases. Prior to the research, most of the participants were under various medical conditions (see Table 2) which demanded daily medications with its associated financial commitments.

AB 66, who hitherto was a diabetic confirms as follows:

> *"I was on diabetes medication, but I have stopped in the course of the study because I think I can regulate my diabetes with the dance movements and food, and I have monitored and realized it has been helpful to me." This testament is consistent with the therapeutic nature of dance and the fact that dance has health benefits that can be harnessed.*

The following participants also had these to say:

> *"I think wellbeing or wellness is very essential at this age, because for me, I went off all medication, I was on blood pressure medication for years but through the choices I made towards a healthy lifestyle, I'm off. So, wellbeing at this age is very important"*
> *(AG, age: 56).*

> *"I think wellbeing is very important at this age, because not being well is expensive, again at this age and era where all sort of things come up and if you constantly go to the doctor it becomes expensive and drains your pocket, so if there is anything you can do to avoid it just do it," (BA, age: 65).*

In conclusion, evidence discussed here demonstrates that DMP has contributed significantly to body and sensory awareness, increased body control, co-ordination, and improved general wellbeing amongst the elderly.

Discussion

The sole objective of this study was to examine the impact of dance movement technique on the general wellbeing of the elderly. This general wellbeing is in connection with their physical, emotional, cognitive, social wellbeing, their coordination, balance, flexibility, mobility abilities and to offer recommendations on dance movement practice as an alternative wellness activity in combating age-related diseases. The goal of this study is to proffer DMP as a wellness tool for fusing into the gerontological healthcare system. The mixed method approach was adopted for the study using participants from the "Dance for fitness" project. An in-depth reflection was then done on the findings to draw an empirical conclusion and make salient recommendations capable of serving as a resource material in adopting DMP as an alternate wellness tool for health practitioners and gerontologist in Ghana and beyond.

Conclusion

A critical analysis of the findings of this study shows that Dance movement as a preventive care medium has improved the general wellbeing; physically, emotionally, socially, and cognitively. Thus, there is the need to reduce pathological treatment and promote this alternate approach to combat their age-related diseases. Ageing is a state of being, which has to do with the whole being - body, mind, and spirit. Therefore, the elderly or the aged should not be treated as a liability but seen as an asset for posterity.

Recommendations

Gerontologists and policy makers should initiate programs to educate, sensitize, entertain, and communicate the wellness benefits of these activities for the elderly. Policies and programs of these kind should be well structured to facilitate movements that are permissible to the elderly due to their age. Policy makers should put infrastructures such as Social Centers or Day Care Centers in place for the aged after retirement where various activities like dancing, storytelling, and childhood games like Ludo, and Oware would be made available. There is the need for policies geared towards improving the wellbeing of the elderly in health institutions and care homes.

Graduates and practitioners of dance studies education from across the country can also be employed in or work hand in hand with gerontologists and elderly caregivers' centers to train them. In addition, it is very important to also sensitize the ageing population to make the right choices in enhancing their wellbeing, by engaging in dance movements, storytelling, games, walk, etc. They should take advantage of these activities and develop the right attitude towards ageing successfully and gracefully.

Implication for public policy

Successful ageing is a socioeconomic need. Therefore, conducting a practical investigation on how dance techniques can improve one's wellbeing can save the high cost of managing the elderly within our society. In Ghana, there is high dependence on the not so adequate health facilities and systems. Thus, in the absence of soma-wellness, national health systems will not be able to stem the cost associated with managing the increasing numbers of individuals suffering from various age-related health problems.

However, through alternate successful ageing methods like DMP, the healthcare system could save cost while the individual enjoys a greater quality of life for a longer period and enable the aged to age successfully.

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Ageism and Attitudes Towards the Aged Among Ghanaians

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Abstract

Attitudes towards the aged comprise feelings, cognitions, and behaviours linked to how individuals relate to older adults. Although the social understanding of relating to the aged have been established in studies, the psychological predictors of these attitudes have not been studied in Ghana. This study assessed the ageism and attitudes towards the aged.

The study was a quantitative study which sampled 323 participants. The present study examined the reasons why adults have certain attitudes and perceptions about the aged. The study investigated this objective from the social and psychological points of view. The study used an explanatory mixed-methods design. The study started with a quantitative study which consisted of 323 participants who were recruited from selected areas in the Greater Accra region. Data was collected using measures of ageism, attitudes towards the aged, fear of old people (FOP). The quantitative data was analysed using multivariate and regression analysis. The results showed that sociodemographic factors such as education and age individually play a role in ageism and attitudes towards the aged, respectively. The study also found that positive ageism reduces negative attitudes towards the aged, whilst negative ageism is linked with undesirable attitudes towards the aged.

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The findings are discussed in relation to the objectives of the study and recommendations provided on how to promote care for the aged and enhancing positive attitudes towards the aged.

Introduction

Ageism refers to negative or positive perceptions or prejudice based on them against (or to the benefit of) elderly people (Iversen et al., 2009). Ageism, when negative, and has been related to poorer quality health services and decreased access to health care (Wilson et al., 2017). Ageism is pervasive and an insidious social inequality that has adverse effects on the mental health of the aged. Ageism is deeply rooted in culture and not many people are cognizant of it. It is exhibited in constrained social services, stereotypical messages portrayed by the media, and marginalization by society at large (Palmore, 2015). Ageism has been classified into personal ageism, institutional ageism, intentional ageism, and unintentional ageism. On the part of individuals, personal ageism involves thoughts, behaviours, values, and activities that are discriminatory towards people or groups because of their chronological age. For institutional ageism, it covers organisational policies and procedures that are not in favour of the aged or older workers. Intentional ageism encompasses thoughts, behaviours, laws, or activities that are conducted based on their older age with the full knowledge that they are blatantly biased against older adults. This entails activities that take advantage of older people's weaknesses (Sporre, 2019).

Age-related negative stereotypes are well known. Research shows that older people are mostly seen as lonely, inept, dependent, diseased, and solitary (Goll et al., 2015). These kinds of negative stereotypes affect not just the lives of the elderly, but also how the younger generation view their own ageing. The

shift in attitudes towards the aged is worrying. This shift, as has been discussed, started because of urbanisation, migration, globalisation, and education (Eboiyehi, 2015; de-Graft Aikins & Apt, 2016). The modernist theory for the shift in attitudes towards the old position that modernization is causing systemic changes in our social structure, leaving many problems for older people that they did not face before modernisation. Again, modernisation, which is not a facet of the African framework, results in individualisation. The pessimistic views of the elderly are harmful to their well-being. Unlike other rituals of life, ageing is something everyone is going to face, which means that the consequences of a society ridden with negative ageism will be faced by all. Given the prevalence of ageism and the ageing population, the factors contributing to the creation of ageist attitudes towards the aged must be understood urgently. A big move forward in healthier treatment would be to have a piece of substantial knowledge and a cheerful outlook towards ageing.

Barnett and Adams (2018) have explored the correlation between ageism and ageing anxiety. They found out participants who had more encounters with older people had more positive attitudes about the aged population. This is consistent with previous research all of which found that similar relationships exist for individuals who are knowledgeable about ageing (Bousfield & Hutchison, 2010; Darling, 2016; Kotter-Gruhn, 2015; Stahl & Metzger, 2013). Similar findings are seen in a study by Wise and Onol (2020) who realised in their research that ageing anxiety among grandchildren of the aged was influenced by the kind of quality contact they had with grandparents, how often they met them, as well as the emotional closeness that was developed. Cooney et al. (2020) executed research to investigate the predictors of ageism and rate the most pressing factors that explain ageist attitudes. A total of 419 participants were used ranging between 18 and 86 completed an online survey. The findings of the study

were that ageing anxiety, contact with the aged, and knowledge of ageing predicted ageism after other demographic variables were held constant.

Nwasogwa and Ugwu (2019) in Nigeria found that females are more positive than males when it comes to attitudes towards the aged. This finding, though divergent from other recent studies can be attributed to the geographical location in which the study was conducted since the above-mentioned studies were conducted outside Africa. Conversely, a much recent study on gender differences in attitudes towards the aged in Nigeria by Afolabi et al. (2020) found that majority of males had much more positive attitudes towards the aged as compared to the female cohort. They also found that female nurses preferred to work with younger patients than older ones.

Method

Research design

A cross-sectional survey was employed to study death and ageing anxieties among middle-aged and older adults. The survey was used to obtain demographic data from participants as well as data on facets of ageing anxiety and death anxiety.

The research was performed in the Greater Accra Region of Ghana. The population of the study consisted of adults who are 18 and above within the selected areas of La Nkwantanang Madina Municipal District, Accra Metropolis District and Tema.

Participants

Participants were recruited by convenience sampling from the Greater Accra region, with most of the participants from the University of Ghana, University of Professional Studies, Madina

and surrounding areas. The participants comprised 159 (49.2 %) males and 164 (50.8%) females. The participants were grouped into 3 namely, young adults 175(54.2%), middle-aged adults 80(24.8%) and older adults 68 (21.1%).

Measures

Ageism

To measure ageism, the Relating to Older People Evaluation (ROPE) was used. The scale is a 20-item measure of positive and negative ageism developed by Cherry and Palmore (2008) This scale has separate subscales that measure positive ageism and negative ageism. Six items comprise the Positive Ageism scale whilst 14 items are included in the Negative Ageism scale. The range obtained for positive ageism was 6–18, and 14–42 for negative ageism.

Attitudes towards Older People

To measure attitudes towards the aged, the abridged version of Kogan's Attitudes towards Older People (KAOP) was used. The Kogan Attitudes towards Old People Scale is used to evaluate the positive and negative attitudes of people towards the elderly. The revised version by (Kiliç & Adibelli, 2011) is a two-part, self-administered questionnaire (positive and negative aspects), with 13 statements in each part. The reliability coefficient obtained for this scale in the study was α=.87.

Fear of old people

This scale is a subscale of the ageing anxiety scale (AAS*)* which is a multidimensional scale developed by Lasher and Faulkender (1993). It was used to measure fear of old people which directly represents fear of ageing in this study.

Procedure

The procedures for data collection involved first conducting a pilot study to assess the questionnaire and the interview guide before conducting the main study. The study started by obtaining ethical clearance from the Ethics Committee for Humanities (ECH) of the University of Ghana for approval to undertake the study.

Results

SPSS version 26 was used to render tabulations of frequencies, percentages, and graphical presentations. All statistical tests were conducted as two-sided and declared at the significant value of p = 0.05.

Table 1. Bivariate Correlations among Criterion and Predictor Variables

	1	2	4	5	6
1.Attitudes					
2.Contact	-.326**				
4.Postive Ageism	-.122*	.493**			
5.Negative Ageism	.265**	.163	.505**		
6.Fear of old people	.604**	-.467**	-.318**	.075	

Correlation is significant at the 0.01 level (2-tailed).
Correlation is significant at the 0.05 level (2-tailed).

Table 3: Summary of MANOVA table for differences in gender on attitudes towards the aged, ageism, at and ageing anxiety

Variable	Gender					
	Men	Women				
	Mean (SD)	Mean SD	*df*	*F*	*p*	η^2
KAOP	80.89±13.59	80.86±14.40	1,295	.000	.984	.000
Negative Ageism	23.70±5.17	21.73±4.21		12.98	.000	.042
Positive Ageism	13.36±2.50	12.97±2.35		1.99	.158	.007

NOTE. SD = Standard deviation; KAOP = attitudes towards older people; $p<0.01$

Difference between men and women were statistically significant on the combined dependent variab*les*, F (1, 295) = 3.57, p = .013; Wilks' Lambda = .94; partial eta squared = .06. When the results for the dependent variables were considered separately, the only variable to reach statistical significance, using a Bonferroni adjusted alpha level of .004, was negative ageism, F (1, 295) = 12.99, p = .000, partial eta squared = .04. A scrutiny of the mean scores indicated that men had marginally higher levels of negative ageism (M = 23.70, SD = *5.17*) than women (M = 21.73, SD = 4.21). Meaning, male participants are more likely to exhibit negative ageist behaviours than females.

To investigate age differences on attitudes towards the aged, a multivariate analysis of variance was done. Three dependent variables were used: attitudes towards the aged, positive ageism and negative ageism. The independent variable was age (which was on three levels). Checks assumptions of MANOVA were done, with no serious violations noted. There was a statistically significant difference between the groups on the combined

dependent variables, F (2, 302) = 18.44, p< .01; Wilks' Lambda = .713; partial eta squared = 1.56. When the results for the dependent variables were considered separately, all the scales reached statistical significance.

Using a Bonferroni adjusted alpha level of .01, attitudes towards the aged, F (2, 302) = 21.77, p = .000, partial eta squared = .13; negative ageism, F (2, 302) = 25.29, p = .000, partial eta squared = .14; positive ageism, F (2, 302) = 19.22, p = .000, partial eta squared = .11.

Table 4: Summary of Results for the MANOVA test performed on the 3 groups

Variables	**Age**						
	Young Adults N=170	**Middle-Aged Adults N=77**	**Older Adults N=62**				
	Mean (SD)	**Mean (SD)**	**Mean (SD)**	***df***	***F***	***P***	η^2
KAOP	82.06 ± 11.24	85.69 ±15.37	71.50[ab*]± 14.56	2,305	170.56	.000	.126
Negative Ageism	21.11[b*]± 4.14	25.17[a*]± 4.84	24.00[c*]± 4.66		25.29	.000	.143
Positive Ageism	12.48[b*]± 2.14	13.77[a*]± 2.41	13.19[c*]± 2.54		19.22	.000	.113

NOTE. KAOP= Attitudes towards the aged scale. p<.01; M (SD) = Mean (Standard Deviation)

[a*] Young Adult is significantly different from middle-aged adults on only negative ageism and positive ageism.

[b*] Middle-Aged Adult is significantly different from young adult on negative ageism and positive ageism.

[ab*] Older adult is significantly different from young and middle-aged adult on attitude towards the aged (KAOP)

[c*] Older Adults significantly differ from young adults on negative ageism and positive ageism.

*= significant at the .05 level of significance

Post-hoc comparisons using the Bonferroni test indicated that the mean score on attitudes towards the aged (KAOP) for young adults (M = 82.06, SD =11.24) was significantly different from older adults (M = 71.50, SD = 14.56). Middle-aged adults (M = 85.69, SD = 15.37) was statistically different from older adults (M = 71.50, SD = 14.56). However young adults and middle-aged adults did not differ significantly from each other.

For negative ageism, young adults (M = 21.11, SD=4.14) reported significantly less ageist behaviours than middle-aged adults (M = 25.17, SD=4.84) and older adults (M = 24.00, SD=4.66). Middle-aged and older adults did not differ significantly on negative ageism.

For positive ageism, older adults (M = 13.19, SD=2.54) reported more positive ageist behaviours than young adults (M = 12.48, SD=2.14). Again, middle-aged adults did not differ significantly from older adults. Therefore, the hypothesis was only partially supported.

A one-way between-groups multivariate analysis of variance was done to investigate educational differences in attitudes towards the aged. Three dependent variables were used: attitudes towards the aged, positive ageism and negative ageism. The independent variable was Education (which was on four levels). Before the test was done, all tests for assumptions were conducted. The results

indicated that there was a statistically significant difference between the groups on the dependent variables, F (2, 302) = 3.57, p = .000; Pillai's Trace = 11.82; partial eta squared = 0.72 When the results were examined independently, only ageism reached statistical significance. Pillai's Trace instead of Wilk's Lambda was reported because some assumptions of MANOVA were not met as suggested by Pallant (2011).

Using a Bonferroni adjusted alpha level of .01, attitudes towards the aged, F (2, 302) = .86, p = .42, partial eta squared = .009; negative ageism, F (2, 302) = 35.18, p = .000, partial eta squared = .19; positive ageism, F (2, 302) = 13.56, p = .000, partial eta squared = .084.

Table 5: Summary of Results for the MANOVA test performed on the 4 groups

Variables	<SHS N=52	Undergrad-uate N=131	Postgrad-uate N=75	*df*	*F*	*P*	η2
KAOP	80.87±18.19	81.74±10.50	79.08± 12.30	2,301	.95	.42	.009
Negative Ageism	25.61±4.94	21.33± 3.75[a*]	21.05±4.26[a*]		23.48	.000	.190
Positive Ageism	14.17± 2.68	12.74± 2.15[b*]	12.62± 2.12[b*]		9.16	.000	.084

NOTE. KAOP= Attitudes towards the aged scale, P<.01; ±=Standard Deviation

[a*]=below SHS participants differ significantly from undergraduate and postgraduate participants on negative ageism.

[b*]=below SHS participants differ significantly from undergraduate and postgraduate participants on positive ageism.

Post-hoc comparisons using the Bonferroni test indicated that for SHS and below (M=25.61, SD=4.94) scored higher on negative ageism than Undergraduates and postgraduates (M = 21.33, SD = 3.75), (M = 21.05, SD = 4.26) respectively.

For positive ageism, SHS and below (M = 14.17, SD = 2.68) scored higher on positive ageism than Undergraduates (M = 12.74, SD = 2.15) and postgraduates (M = 12.62, SD =2.12). Undergraduate and Postgraduate participants also did not differ from each other on measures of ageism. .

There was a negative correlation between positive ageism and attitudes towards the aged, r=.-.12, n=320, p<.05 with high levels of positive ageism associated with lower levels of negative attitudes towards the aged. Also, there was a small positive correlation between negative ageism and attitudes towards the aged, r= .27, n=318, p<.001, meaning, an increase in negative ageism leads to an increase in negative attitudes towards the aged; also, a decrease in positive ageism leads to an increase in negative attitudes towards the aged.

Table 8: Summary of the results of the Moderation effect

Model	***B***	***SE***	***t***	***P***
Constant	80.82	.612	132.122	.000
Negative Ageism	.65	.133	4.893	.000
Fear of old people	1.94	.181	10.719	.000
Int_1	.074	.033	2.261	.024

B=coefficient/ slope of the intercept; SE= standard error; p=significant level; Int_1= interaction

To test the hypothesis that Fear of old people will moderate the relationship between negative ageism and attitudes towards the

aged, simple moderation analysis was performed using Model 1 of the PROCESS macro version 3.4 by Hayes (2019) with a confidence interval of 95% and bootstraps set at 5,000. The outcome variable for analysis was Attitudes towards the aged (KAOP). The predictor variable for the analysis was negative ageism. The moderator variable evaluated for the analysis was Fear of old people (FOP). The variables accounted for a significant amount of variance in attitudes towards the aged, R^2=.42, F (3,299) =57.38, p<.001.

The interaction between the predictor and moderator variables was found to be statistically significant {b= .074, 95% C. I (.01, 0.14), p<.05}, indicating that the relationship between negative ageism and attitudes towards the aged is moderated by fear of old people. Thus, the hypothesis that Fear of old people moderates the relationship between ageism and attitudes towards the aged was supported.

The conditional effect showed corresponding results. At low moderation, there is no significant relationship between negative ageism and attitudes towards the aged, {b=.-35, 95% C.I (-.05, .75), p>.05}. However, at high moderation, there is a significant relationship between negative ageism and attitudes towards the aged, {b=.95, 95% C.I (.62, 1.29), p<.05}.

Discussion

One objective of the study was to examine whether socio-demographic factors (age, education, and contact with the aged) influence attitudes towards older people. On age differences, it was observed that young adults and middle-aged adults had more negative attitudes towards the aged than older adults. However, among the two, they did not differ on which group had more negative attitudes. Studies by Liou (2017) and Makita

et al. (2019) have reported similar findings. A striking finding, however, was that young adults had lower scores on negative ageist behaviours than middle-aged and older adults. Middle-aged adults, from the results, had slightly higher means on negative ageism than older adults however, it was not statistically significant.

The current study found out that educational level does not have any influence on attitudes towards the aged. For ageism, however, participants with higher education had less negative ageist attitudes than those with lower education levels. Interestingly, however, respondents with lower educational levels scored higher on positive ageism than those with higher educational levels. One justification for this would be that participants with higher levels of education treat the elderly without any implicit bias thereby negating the Stereotype embodiment theory. It can further be argued that education reduces age-related biases which have been socially constructed as the stereotype embodiment theory suggests. This finding is concordant with others which found that higher academic levels have a positive relationship with intention to work with older adults (Che et al., 2018; Goncalves et al., 2011; Koskinen et al., 2012).

Finally, correlation analysis showed that as contact with the aged increased, negative attitudes towards the aged decreased. This finding is consistent with current research such as that of Cadieux et al. (2019) who found that more contact with older people leads to developing more positive attitudes towards the aged. This supports the Contact Hypothesis which posits that contact with the outgroup will reduce prejudice and foster good relationships. Previous research has found similar findings on the positive effect contact has with attitudes towards the aged (Bousfield & Hutchison, 2010; Hutchison et al., 2010). However, contact with the aged was significant only in the first model of the

regression analysis which suggests that it cannot be established as a predictor of attitudes towards the aged despite the negative correlation.

The current study found that as positive ageism increased, negative attitudes towards the aged decreased. Although positive ageism is ideal, considering that it results in a positive attitude towards coping with older adults, it would be better to have a more realistic view of older adults as real individuals, just like younger ones, and not have to rely solely on positive ageist attitudes.

Fear of old people was measured using items that dwell on contact with older people. Contact hypothesis is inherently involved with the aged since fear of the aged is based primarily on contact. The five items centred on levels of contact individuals have with the aged. The moderation analysis conducted contextualised the relationship between negative ageism and attitudes towards the aged. The conditional effect from the analysis showed that as fear of the aged increased, there was a positive relationship between negative ageism and attitudes towards the aged.

Implications of findings for clinical practice

The main findings confirm that fear of old people and ageism may affect attitudes towards the aged, and more contact with the aged reduce negative attitudes. With the clear increase in ageism and negative attitudes towards the aged, psychologists may encounter much other older adults who will present with psychological disorders such as anxiety, and typically depression as emphasised in the study by Bonful and Anum (2019).

Recommendations

From the research conducted, suggestions and recommendations for dealing with ageing in Ghana are listed below; they could be considered both as solutions for the immediate, transitional, and long term. To make known the value of ageing and the possible consequences if it is not addressed, ageing needs to be promoted; this has the potential to support evidence-based policies and will make more societies responsive to ageing:

- Organisations in Ghana should endeavour to help solve problems which are ageing-related and not put all focus on just children and the young adult population.
- The government must enact and enforce legislation that borders on ageing issues in detail and policies such as the Livelihood Empowerment Against Poverty (LEAP) and other policies must be fully functional with ample results.
- Lastly, given knowledge on the increasingly ageing population, the sustainable Development Goals should be restructured to accommodate the elderly, as the SDGs are not specific to ageing.

Limitations

This study was constrained in many ways. The use of a convenience sample restricts the generalizability of outcomes since most respondents were in higher institutions or graduated from higher institutions. The expansion of the sample size to include individuals of diverse educational and geographical backgrounds that this study attempted would be beneficial for further research. Contact with older adults and ageism is also likely communal with respect to the variables; that is, contact with the aged may have an impact on ageist attitudes, likewise, ageist

attitudes may also lead to contact with older adults. Conducting a longitudinal study may be of benefit to explain the relationship between contact and attitude towards the aged.

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Young Adults' Perception of Ageing and Care of Older Adults: A Study Among University of Ghana Students

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Abstract

Globally, the rate of population ageing is high. Similarly, Ghana faces a threat in witnessing rapid ageing of its population. Traditional social systems that were used to care for older adults are rapidly collapsing due to changes in the society. The present study explored young adults' students' perceptions of older adults in Ghana, through the exploration of their understanding of the term ageing and old age, their attitudes towards caring for older adults along with the roles they play in their care. Through a qualitative approach, individual interviews were conducted with 20 young adults in the University of Ghana. Findings show that students held stereotypes about older adults, but they were not aware of the ageing population and its implication on their wellbeing. The findings also revealed that young adults performed house chores and other minor activities to support older adults. Findings from this study suggest the need for information on ageing in tertiary schools to enhance students' knowledge on ageing and the implications of ageing population.

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Introduction

Ageing is inescapable for everyone and has become a global phenomenon. It is used to describe a series of time-related processes occurring in the individual that ultimately brings life to an end. Ageing influences an organism's entire physiology by impacting on all levels of functioning, and increases susceptibility to major chronic diseases (Eboiyehi, 2015; Vijg, 2007). Over the past decades, there has been a rapid acceleration in the ageing population both in developed and developing countries. According to a recent report by the Population Division of the Department of Economic and Social Affairs of the United Nations (2017), the global population of those over 60 years has increased more than twofold since 1980 to 2017 from a population of 382 million to 962 million. The report added that the population of older adults is likely to double again in 2050 to a projected population of 2.1 billion. It is estimated that, the worldwide population of older adults from age 60 and above will continue increasing at a rate of 3.2% yearly (Ghana Statistical Service, 2013).

A report from the United Nations has revealed that in the coming decades, the number of older persons is expected to grow fastest in Africa, where it is predicted that the aged population will increase more than threefold between 2017 and 2050, from a population of 69 million to 226 million (United Nations, 2017). In addition, the population size of older adults is estimated to overtake the population of the youth between the ages of 10 to 24 globally (United Nations, 2017). Reports further indicate that in the next few years, it is likely that the ageing of the population will be accompanied by a rise in the number of people requiring care (Doblhammer & Vaupel, 2010). As is the case of developing countries in the world, Ghana is currently witnessing rapid ageing of its population (World Health Organization, 2014). The

population of older adults in Ghana has increased more than seven-fold from 213,477 in the 1960 census to 1,643,381 in the 2010 census (World Health Organization, 2014). The increase is due to declining fertility rates, decrease in global mortality and increasing life expectancy which Ghana is no exception (Ghana Statistical Service, 2013).

Young adults' perception of ageing

Regardless of the alarming increase in the ageing population, several research studies conducted on young adults' perception of ageing indicate that college students have low knowledge about aging and several misconceptions about older adults (Kimuna, Knox, & Zusman, 2005; Stuart-Hamilton & Mahoney, 2003; Tan, Hawkins, & Ryan, 2001). For instance, researchers have reported perceptions such as older adults being socially unskilled, senile, verbose, and rigid (Kimuna, Knox, & Zusman, 2005; Robinson & Anderson, 2006; Zhang, et al., 2006). Others label older adults as forgetful, useless, and financially distressed (Blakeborough, 2008). In a Nigerian study, Okoye and Obikeze (2005) found that majority of youth believed that older adults act like children and thus need more support from them. Robinson, Gustafson, and Popovich's (2008) study also revealed that young adults were aware of the stereotypes used to portray older people, understood how it offends older adults and its harmful consequences. Stereotypes and beliefs of younger people held about older adults contribute to denying them opportunities and equitable care (Minichiello, Browne, & Kendig, 2000). Despite the negative attitudes reported in some studies positive attitude have also been reported. Some young adults describe older adults as kind, supportive, wise, and having experience (Zhang et al., 2006).

Studies have observed that younger generations across Africa are expected to support older adults because of the traditional expectations of children serving as social insurance to their parents in old age (Arkorful, 2015; Oppong, 2006). This results from many older adults not having worked in the public sector which results in them not receiving any pension benefits. Oduro (2010) argues that at old age, children (young adults) and grandchildren of the older adults become their support. Most of the young adults who may be available to take care of older adults may be students. Students care for older adults by providing informal support to them. For example, students may help the aged by cooking, shopping, assisting them to with physical activities and providing psychological support to aid their survival in old age (Eboiyehi, 2015).

Although studies have been conducted on the attitude of college students towards ageing older adults, there is scant research on the subject among Ghanaian students. College students' attitude towards older adult is worth studying due to the changing phase of care provided to older adults in Ghana.

In the past, the family system relied on to care for older adults in the traditional African society. Every individual in the family and community is seen to have social responsibility for the other person. Similarly, caring for older adults was the concern of the family and community members (Eboiyehi, 2015). However, recent reports show that there is less contact between the youth and older adults. Furthermore, in the Ghanaian society wisdom is attributed to old age, as a result young adults seek guidance and counseling from older adults. Due to this perception of older adults being wise, they are assigned responsibilities such as family heads, officiating marriages, naming ceremonies, funerals and settling conflicts. However, recent report shows that respect is not given to older adults due to negative perception held

by the society (Frimpong, 2015), leaving them neglected. It is against these drawbacks that this study explores the perception of ageing of young adults who are pursuing their undergraduate education and how these perceptions influence the support they give to older adults in the Ghanaian context. Specifically, the study sought to answer the following research questions: 1. What are the perceptions of young adults on the concept of ageing and old age? 2. What roles do young adults play in caring for older adults? 3. What are young adults' attitudes towards caring for older adults?

Method

Research design

The present study used an exploratory qualitative research design. This design enables the exploration of individual reasons and opinions about a subject. One-on-one semi-structured interviews were used to collect data from participants.

Participants

A sample of twenty (20) young adults undergraduate students in the University of Ghana were selected to serve as key informants for the study. Participants were selected through purposive and convenient sampling techniques which enabled the researchers to obtain participants who met the inclusion criteria and were willing to share their views on the topic of interest. Twenty (20) participants were deemed adequate given the aim to improve the exchange of information (Crouch & McKenzie, 2006). Out of twenty participants, ten were males and ten were females. Nine of the participants were freshmen of the university and the remaining eleven were continuing students. Their ages ranged

from 18 years to 26 years. Other demographic information is presented in Table one below.

Table 1 Demographics				
ID*	Level	Age	Gender	Religion
Pt.1	100	22	Male	Christian
Pt.2	100	18	Male	Christian
Pt.3	100	22	Male	Christian
Pt.4	100	20	Female	Christian
Pt.5	200	23	Male	Christian
Pt.6	200	23	Male	Christian
Pt.7	200	21	Female	Christian
Pt.8	200	21	Male	Christian
Pt.9	100	18	Male	Muslim
Pt.10	200	20	Female	Christian
Pt.11	300	21	Female	Christian
Pt.12	200	20	Female	Christian
Pt.13	100	18	Male	Christian
Pt.14	100	18	Female	Christian
Pt.15	400	23	Male	Christian
Pt.16	400	23	Female	Christian
Pt.17	400	26	Male	Christian
Pt.18	100	25	Female	Christian
Pt.19	100	19	Female	Christian
Pt.20	300	20	Female	Christian

Trustworthiness of the results

Shenton's (2004) suggestions for achieving the four criteria (i.e., credibility, transferability, dependability, and confirmability) of trustworthiness of the findings were followed. To achieve credibility, the researchers critically analyzed the data enhancing the quality of the analysis. To ensure transferability, detailed information on how the data was gathered has been provided. To achieve dependability, the researchers established grounds for replication of the study by clearly stating the step-by-step process in gathering and interpreting the data. To achieve confirmability, the data collected, and the interpretations made were not based on the researchers' own imagination. However, the researchers ensured that the data collection was without any personal biases. The data was collected with the aid of a recording device to ensure that the actual information received from the participants is presented.

Ethics and procedure

Ethical clearance was approved by the Departmental Research and Ethics Committee (DREC) of the Department of Psychology, University of Ghana. The participants were given appropriate information about the research, after which their consent was obtained. Participant's privacy was ensured by protecting the data collected from the participants and ensuring that only the researchers have access to the data. Also, the participants were made aware that they can withdraw their participation at any time in the research and that if for any reason they decide to withdraw from the study, the information they had given would be destroyed.

Following ethics approval, the author met with individuals who were willing to participate in the study. The time and venue for

the interview were scheduled to suit the participant's schedule. The interviews were conducted in empty lecture halls and residential rooms of participants who resided around campus. Informed consent was obtained from participants and a brief description of the research was given before the interviews began. The researchers used an interview guide purposely developed for the study to gather information from participants. Responses were recorded electronically and manually and used for transcriptions. Sample interview questions include: 1. In your opinion, what is ageing? 2. Who do you recognize to be an older person (aged) and why? 3. Can you describe what you know about the ageing population? The duration of the interviews ranged from 20 to 30 minutes.

Data analysis

Transcribed interviews were analyzed using thematic analysis. In this research Braun and Clark (2006) six step framework which entails familiarisation with data gathered, generating initial code for analysis, searching for themes based on the initial codes, reviewing themes in addition to defining and naming of themes and report writing was used. The interview data collected in the field were transcribed verbatim, read through, coded line-by-line and categorized into themes in line with the research aims and objectives. The steps used in analysing the data collected are shown in Figure 1 below.

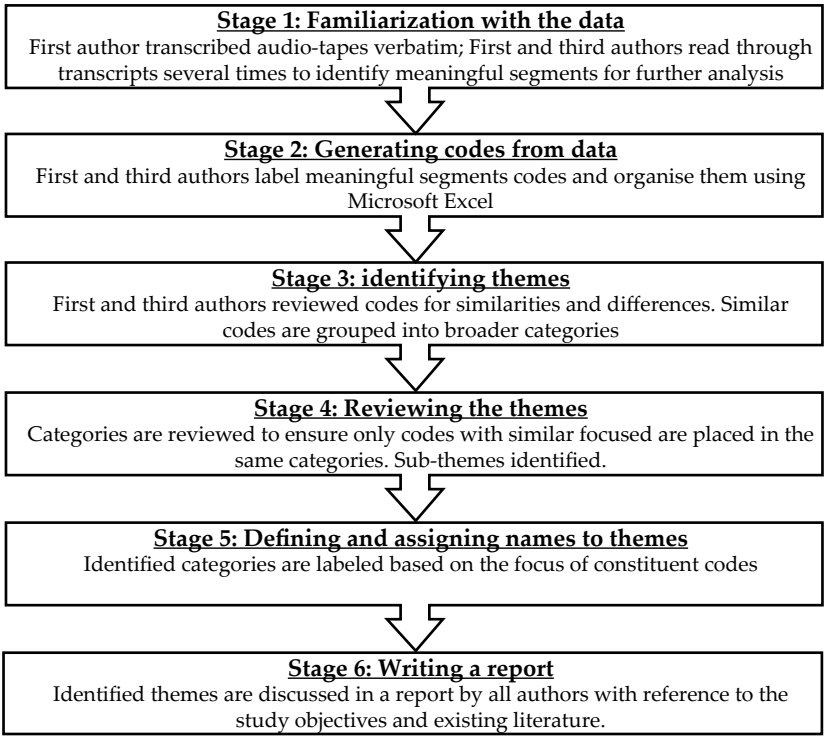

Fig 1: Flow chart representation of thematic analysis.

Results

Following the data analysis, three major themes were identified which included perceptions of ageing and older adulthood, attitudes towards older adults and attitudes towards caring for older adults.

Perceptions of ageing and older adulthood

This theme addresses students' general knowledge on ageing and older adulthood. First, the participants' understanding of

the concept of ageing was explored and second, their views on what constitutes older adulthood were explored. Ageing was perceived to relate to the number of years one has lived, that's the individual's chronological age, and a continuous process in which people transition from one stage of life to another.

> *"Ageing has to do with growing old in society. Especially the age from 60 above are considered most widely as the aged…"* (Pt. 15, male, 23 years).

> *"when we talk of ageing, it is like a period that you move from one stage to another … You grow by age, so ageing is the ranges. You step from one stage to another in life, that's it …"* (Pt. 8, male, 21 years).

The transitional nature of ageing was perceived to relate to physical strength possessed by the growing individual. In this sense, childhood and older adulthood were perceived to be the stages for weakness whereas early and middle adulthood were perceived to represent the stage of life where the individual is strongest.

> *"…When I was little, my dad used to say something about when you are growing. When they gave birth to you, you just start life from day one you came into the world you are climbing a mountain. But when you get to 50 you are descending the mountain. From that age 1 to 50, you are getting stronger and stronger but from 50 downwards you are getting weaker and weaker. Because the things they did it back then, now they can't do …"* (Pt. 1, male, 22 years)

> *"What I think about ageing is, basically it is a natural phenomenon that occurs as a result of living. Like the more you grow. When you are born, you are a kid [you know] so the moment you are growing that is what is meant by ageing."* (Pt. 17, male, 26 years).

Second, participants' views on features of older adulthood were explored. In this regard, the number of years one lives was cited as a major criterion for identifying an older person. However, there were variations regarding the exact age to call a person an older adult. Most participants cited between 60 and 70 years as the cut-off age. While chronological age was important, the individual's level of independence, ability to perform their daily activities and work were closely linked with the chronological age. To these participants, once a person is unable to function without assistance, the individual assumes the older adult status. But those who can work despite being older than the 70 years cut-off age were not perceived to considered as older adults.

> *"… From 70 years. Because I see many people who are 60 and some are stronger than even some in the government institutions who are still working though they are supposed to go on pension. Yes, that is why I think 70; those who are 70 are the aged."* (Pt. 10, female, 20 years)

> *"…I will say from 70 and above because, I know people who are 60 and are still strong… I think when you get to your 70s that is when age catches up. Normally it depends, some of the aged despite them being old they still have the capacity to withstand any event around them…"* (Pt. 17, male, 26 years).

For other students, the constitutional retirement age, which is 60 years, was cited as the cut-off for older adulthood irrespective of how functional the person is.

> *"…According to our laws, someone who is aged is above 60 that's the time for retirement… I will take it as 60. As is generally accepted…"* (Pt. 3, male, 22 years)

> *…In Ghana, … you are still relevant to the system till you are 60 years. You can work till 60 years but, it is assumed that after 60 years you need to go on retirement. Basically because of your*

> *strength and the need for someone to also take up that place and learn from you… Someone above 60 is basically considered as an aged…"* (Pt. 16, female, 23 years).

Third, participants were asked of their knowledge of the rate of ageing in the Ghanaian population. In response to this, some participants said they had no knowledge of the increase in the population of older adults in Ghana.

> *"Not really. I haven't taken time to look at it."* (Pt. 14, female, 18 years)

Few participants indicated that although they were not aware of the specific rate of growth, they have noticed the presence of many older adults in several parts of their communities.

> "*...Yeah, because in our society today everywhere you go you will see the aged around."* (Pt. 1, male, 22 years).

> *"… Because every house has an old man or woman …"* (Pt. 8, male, 21 years).

Other participants reported that population of the youth is more than that of older adults so to them, they do not see an aging population.

> *"…The youth are more than the aged because, per my study I think the youth are more.... Nowadays you will go to a company you will see someone 26 or 27 years managing the company…* "(Pt. 3, male, 22 years).

> *... The last I checked, the long-time then [hmm] about 15 to 20 percent. [Ooh] the youth are more..."* (Pt. 6, male, 23 years).

Attitudes towards older adults

This theme highlights students' attitudes towards older adults, which were positive and negative. Positive attitudes pertained to older adults being perceived as experienced and possessing higher reasoning abilities, over time they perceived such older adults will develop foresight which young adults lack. Due to the extensive knowledge, they possess, older adults were believed to deserve respect and should be consulted in critical decision.

> *"…They are people we have to look out for because they have the experience and the knowledge we don't have and give the necessary accord that is to be given to them. We should show respect to the aged…"* (Pt. 7, female, 21 years).

> *"…Because of their experiences…they know that if you go this way, this is how it will turn up. Some also know that if you go that way this is how it will turn up... There are some decisions they will make, if you think about it, you will realize that they were right. Or sometimes you will not realize what they meant until you have experienced it, [okay]… Sometimes most of the things they say though they have reasons, and they have anticipation for them, they are not able to clarify what exactly they are talking about. Some they do things because of their experiences …"* (Pt. 15, male, 23 years).

Some students viewed older adulthood as a blessing. They responded that not everyone will live long to reach certain ages. As a result, when a person gets to that age, he or she is considered to have received God's blessing. Most students believe that 70 years is God's given age and to exceed it is a special blessing.

> *"…70 as the maximum but when you exceed it, it's grace. So, if God gave 70, that means that 70 is the maximum…"* (Pt. 18, female, 25 years)

> *"…70 is when the Christians believe that God has blessed you, so the age after 70 is a bonus life …"* (Pt. 7, female, 21 years).

Nevertheless, not all students held favorable perception about older adults as some participants also expressed negative perceptions about them, which outweighs the positive ones. Participants refer to older adults as feeble, babies, lonely, and socially awkward individuals who need constant assistance to function.

> *"…The aged people are like babies. They see things differently because their minds are a bit not there...they are feeble at that moment so they need people who will be around, like show them how far they have come. Because being an aged person is not that easy it comes with a lot of challenges. It's like their peers some are gone, and they are the only ones and now how they relate to people are a problem…"* (Pt. 3, male, 22 years).

> *"Growing old comes with difficulties. Sometimes the way … they move and the way they do things becomes slow in a way. Sometimes they get tired while walking…"* (Pt. 15, male, 23 years).

Similarly, students also perceived older adults as authoritative, selfish, and manipulative individuals who like to impose their feelings and experiences on others. They also reported that older adults can be difficult to understand and manage as they prefer to do what they want for themselves without taking other people's perspective into consideration.

> *"…They are authoritative because that is what they enjoy doing ok. That is what they love, that is what they cherish, they like to bully people. … They just like to control people. So, if they don't get anybody to control around them, they will call people to come for them to control. Some just like to control. Others too would*

> *want to worry people because they feel when they worry others that is what also makes them happy."* (Pt. 15, male, 23 years).
>
> *"…Maybe you are used to sleeping around … 8–9 [pm] and they are used to sleeping 6 or sometimes 5:30[pm]. They close all the doors and lock all the things up. Another thing could be, you are used to listening to radio or watching the TV with an average volume, but they want it as low, below average and you don't understand them. Another experience is, sometimes when you live with them, they tell you things to do and things you shouldn't do, you wouldn't understand …"* (Pt. 4, female, 20 years)

Furthermore, participants also reported that older adults tend to forget too quickly and frequently.

> *"… Let's say like they want to take something from the room. They will go into the room … and forget what they want. It does happen to everybody, But the degree at which it happens to them is more*." (Pt. 14, female, 18 years)
>
> *"… Because of their old age they forget, and they keep calling you …their memory is fading faster as compared to yours…"* (Pt. 3, male, 22 years).

Some students reported that the older adulthood comes with many regrets. Regrets could emanate from their inability to accomplish certain goals or being unable to perform certain tasks they used to be able to perform in their youthful stage.

> *"…Sometimes they compared their youthful life to their old age. … that person will be like … I wish I'm still young, I could have done this on my own. I could have gone that way. I could have done that. I could have done this. Meanwhile they don't have the strength. So, they feel that sometimes they are victimized, because they don't have the capabilities they used to."* (Pt. 15, male, 23 years)

> *"…You know some people still feel regret. Regret can also be a challenge because they regret not doing something in their youthful age to make them better or to inspire people or to change life. They might regret…"* (Pt. 18, female, 25 years).

Participants' attitudes also reflected in how they relate with older adults. During the time they spent with older adults, the participants described older adults as complicated and difficult to understand due to the generational gap. This complexity makes it difficult for them to reach consensus on issues.

> *"… We are from different generation, so they find it hard to understand how things work now... sometimes you have somewhere important to go and maybe you are only left with your grandma at home. You don't know her whereabouts so maybe you have to compromise. You need to stay at home and watch her."* (Pt. 6, male, 23 years)

> *"… Sometimes …when she has eaten and you ask her, "has she eaten?" She will tell you, "no." When someone comes around and asks her, if she has eaten, she will tell them, no. I know of one [older adult], she speaks a lot like, when you come to pass her compound, she will sack you to go back. They behave awkwardly, like sometimes she will sit down, and she will be talking by herself."* (Pt. 11, female, 21 years).

Some participants referred to older adults as illiterate and saw the need to educate them. Some also pointed to difference in technology and the older adults' gap in knowledge on this.

> *"… You can also help them because most of them aren't learned, they weren't able to go to school so you are knowing certain things, you can put them through because the world is evolving and its becoming technology, technology everywhere. So, you have to make them understand and make them flow with the*

world by teaching and explaining some things to them…" (Pt. 1, male, 22 years).

Attitude towards caring for older adults

Given the negative perceptions participants had about older adults, we were also interested in whether they were willing to aid older adults and their reasons for helping, and the nature of support they offer to them. Most students expressed their willingness to help older adults indicating that it is a blessing and a privilege. Some felt the need to help to gain similar assistance when they also become old themselves and need the assistance of other people:

> *"I will continue helping them. … it is a blessing. I don't do it because we are supposed to do it. I do it because of the implication and because I know it will help me. Because I like helping people. …"* (Pt. 2, male, 18 years)

> *"… I think I will also grow and be of that age. If I don't do it now maybe someone might not even do it for me. Sometimes what you do that's what is reciprocated to you*." (Pt. 11, female, 21 years)

For other participants, their willingness was conditional on whether it will inconvenience them especially when they perceive their actions will affect their daily activities and when they perceive the older adult needs help.

> *"…They are willing to only if it is convenient for them. … Maybe, during the festive seasons most people go to their villages to live with the aged, [and] speak with them."* (Pt. 6, male, 23 years)

Some students also reported that the distance between the youth and older adults limit how much assistance they can offer them. They admitted that because many older adults live in the rural

areas, it is difficult for the young adults to travel down to assist the older adults.

> *"…I will say urbanization because, everyone wants to come to the urban areas and …big percent of these aged do not feel like coming to the urban areas. Because for instance, in my grandmother's case, my mother [said] she should come here and she [responded that] she has a farm there and she can't leave it."* (Pt. 1, male, 22 years).

> *"Not really. Like now nobody [students] wants to stay in the village."* (Pt. 11, female, 21 years)

Essentially, it emerged that religious teachings and childhood upbringing motivate some students to help older adults. The uncertainty about future happenings causes fear in some students to care for older adults knowing that in future they will not be deserted. Participants said the charity work of their religious groups and church leaders built their interest in the welfare of older adults.

> *"…In the bible, it is also stated that we should honour our father and mother so that thy days will be long on earth. That is the only command that goes with a promise. So, from the look of things anybody that is older than you that you can call mother or father you should respect and obey the person..."* (Pt. 1, male, 22 years).

> *"There is this man of God who … gives medical help to the aged. He always has them at heart. If they need financial assistance, he gives it to them, health he gives to them and spiritually, he supports them. My religion has made me know that when I'm a responsible person in the society I can also do the same thing. Because of the man of God, what he is doing in his church."* (Pt. 7, female, 21 years).

Discussion

This study explored the views of 20 young adults of University of Ghana about ageing, their attitudes towards older adults and their care. Three major themes emerged from the data: perceptions of ageing and older adulthood, attitudes towards older adults and attitudes towards caring for older adults. Findings of the study suggest that the description and understanding of aging and older adulthood differ from person to person. Majority of the students view ageing as part of human life and older adults as blessed by God which may be attributed to the experiential knowledge they have as some participants have relatives who are older adults (Eboiyehi, 2015). Participants had different criteria for judging who qualifies as an older adult. They indicated that an individual must be 60 or 70 years to be identified as an older person. Some students referred to ageing as a cycle, where older adults are at the end of the cycle. Owing to this belief, they perceive that older adults are bound to face many challenges at that stage of their life. Our study also revealed that students do not have enough knowledge of older adults. This finding supports evidence in previous research by Okoye and Obikeze (2005) in Nigeria that shows that younger adults are not informed on the aging population and how it affects the life of everyone. Most of the students in our study were also not aware of the presence of older adults in their community. They place no relevance on knowing something about older adulthood and older persons.

Similarly, the participants believed that older adults have physical limitations. This supports the wear and tear theory, which explains that the human body begins to deteriorate at certain ages (Lange & Grossman, 2010). Mosher-Ashley and Ball (1999) also found similar results in their study, that students perceived older people to have physical problems. The findings

also support the use of labelling and negative stereotypes to refer to older adults. This includes selfish, authoritative, manipulative, forgetful, feeble, and regretful. Dosu (2014) suggests that older adults engage in societal upbringing of the youth in a typical Ghanaian society and as a result these perceptions may influence the students' attitudes towards older persons.

Participants perceived older adults to be experienced, having foresight and high reasoning capabilities. Students who have parents or close relatives who are older adults gave positive perception about such individuals. This finding is in line with findings by Kimuna, Knox, and Zusman (2005) in United States, which shows that students' perception can be influenced if they live with an older person. This finding further suggests that to improve younger adults' perceptions and attitudes of older adults, there is the need to provide younger adults with experiences of living with older adults.

Eboiyehi's (2015) study on how the perception of old age have implication for care and support for older adults revealed that factors such as migration, unemployment, westernization, and industrialization were the underlining influences of care given to older adults. Similarly, in the current study students indicated that older persons are in the villages and the youth come to the cities to further their education and get employed in the city and forget about them in the villages. On the other hand, according to the students, older adults see the village as their comfort zone and always want to live there irrespective of how enjoyable others describe living in the cities to be.

It was also evident in our study that students perceived older adults to be rigid and unable to accept or adapt to change (Lange & Grossman, 2010). This is reflected in participants' report of older adults' inability to adapt to technology. Furthermore,

participants also indicated that technology has affected the way students relate with older adults. In that the nature of support offered by students to older adults cannot be done with technology, but demands their presence (Oppong, 2006). Due to this, students are unable to effectively support older adults as they are unable to provide physical support due to differences in schedule and their personal concerns. Students further indicated that caring for older adults is complicated, in that it becomes difficult to reach an agreement on issues due to the generational gap. Keeping up with the psychological changes they go through becomes frustrating to young adults. Previous research reported that young adults describe their relationship with older adults as difficult, frustrating, repetitive, and slow (Van Dussen & Weaver, 2009).

Despite these negative stereotypes students have about older adults, they were willing to provide care for older adults because they felt that helping older adults secures their future to receive God's blessing. Also, the work of religious leaders and training received in childhood motivates some students to care for older adults. This is in line with study by Malik and colleagues (2016) in Pakistan where the people believed strongly that they will be rewarded and given something good later life or after death, when they perform good deeds. Participants indicated that caring for older adults involves showing good qualities, performing house chores, cooking, and running errands as well as providing material and psychological support to ensure their survival in older adulthood (Eke, 2003). In addition, participants indicated that younger adults need to offer support to older adults because older adults depend on their children when they are no longer capable of productive activity and when they begin to suffer from illnesses that limit their movement and ability to conduct tasks which is essential for daily survival (Oppong, 2006).

Recommendations for intervention

One of the key findings of the present study is the lack of knowledge about ageing and older adulthood. This finding highlights the importance of implementing measures to create awareness about older adulthood among young adults. This recommendation can be implemented by incorporating topics on ageing and older adulthood in educational curricular. Younger adults would also benefit from the opportunity to interact with older adults. This will provide younger adults with experiential knowledge of the lives of older adulthood, including their strengths and weaknesses, which may help to change the negative stereotypes that younger adults hold about older adults. It is also recommended that studies about the aged (gerontology programs) need to be encouraged in tertiary education. Through education students' perception and attitudes of the aged can be influenced. This will help drive ageing related research to inform public policies and pressure groups decisions.

Limitations and recommendations for future studies

The main limitation of the study pertains to the use of smaller sample as only the views of twenty young adults were reported for the study. This limited the diversity of view obtained in the study. Future study should consider employing a large and representative sample of young Ghanaian adults to ascertain a representative view that could be used to inform policy making. A larger representative sample will also make room for generalization of the findings.

Conclusion

This study observed that students do not have adequate knowledge about ageing and older adulthood as their knowledge

base is focused on young adulthood. The study also revealed that the students have negative stereotypes about older adulthood which negatively impact on their attitude towards their care.

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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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Ageing with a Disability: Care Arrangements and Support Needs in Contemporary Ghana

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Abstract

The population of older people is increasing globally, and it is expected that in Africa, the population of older persons would increase from 69 million in 2017 to 226 million by 2050. The United Nations estimates that over 46 per cent of older persons have disabilities, the majority of whom experience moderate to severe disability. Given the increasing trends of older people and the vulnerability of older people to a disability, the population of persons with disabilities could increase. Ghana is yet to develop holistic measures that could adequately address the needs of both persons with disabilities and older people as distinct groups, and uniquely for older persons with disabilities. For example, although the Persons with Disability Act was passed in 2006, a legislative instrument has not yet been developed to operationalize the Act, nor has the Act been harmonized to align with international laws. Persons with disabilities in Ghana face many barriers to full and equal participation in society, including stigma, discrimination, physical and information barriers. On the part of older persons, although there is the National Ageing Policy (2010), more work is required to enforce its implementation to give older persons in Ghana a better quality of life. Undoubtedly, age-related challenges could adversely worsen the plight of older persons with disabilities. Guided by the theory of intersectionality, the life-course theory of ageing, and the social model of disability, content analysis and personal conversations, this paper explores the vulnerabilities and needs of older persons with disabilities in

Ghana and provides recommendations to address their unmet needs.

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Introduction

Globally, more than forty-six per cent of older persons have disabilities; and more than 250 million older people experience moderate to severe disability (UNDESA, 2021). The United Nations (2015) report on population suggests that the number of older persons continues to increase in most countries and regions, and this growth is expected to accelerate in the coming decades. In Africa alone, the population of older persons is projected to increase from 69 million in 2017 to 226 million by 2050 (UNDESA, 2021), with many of them living in West Africa (Ayete-Nyampong, 2015). The number of elderly persons in Ghana is also rapidly increasing and is likely to witness the most rapid rise in the population of older adults in the West African sub-region (Ayete-Nyampong, 2015). Since older people are susceptible to acquiring a disability, this has implications for the population dynamics of persons with disabilities (PWDs) as well. Consequently, the population of persons with disabilities could increase, given the increasing trends of older people. Meanwhile, the inclusion of PWDs continues to be challenging, especially in Ghana due to prevailing negative social-cultural beliefs and perceptions leading to stigma and discrimination; as well as inaccessibility/limited access to the physical environment, transportation, and information (Badu, Agyei-Baffour & Peprah, 2016; Mills, 2018; Naami, 2019; Naami, 2015; Tijm, Cornielje, & Edusei, 2011).

Furthermore, in Ghana, whereas families have historically been the major sources of support for their vulnerable members,

there is growing evidence that kinship care is declining due to modernization, urbanization, and migration (Dako-Gyeke, 2014), and to make matters worse, research suggests that PWDs are receiving less support from their families because of stigma and discrimination (Naami & Liese, 2012). These dynamics have implications for the extent of familial care and support that older persons with disabilities could receive, being one of the vulnerable populations in Ghana.

The population of older persons with disabilities are arguably an important subpopulation whose needs ought to be assessed (McCausland et al., 2010), in view of the multiple vulnerabilities they experience stemming from the intersection of old age and disability. Some existing studies report on various deprivations among older persons with disabilities, including social relationships, information, healthcare, basic literacy and numeracy skills, personal activities, and material well-being (McCausland et al., 2010; Mitra et al., 2020; Strydom et al., 2005). Other studies assert that the occurrence of disability has implications on the quality life of older people (Calmels et al., 2003; Peruzza et al., 2003); while other research indicate that older people with disabilities may have poor perceptions about their health levels (Johnson & Wolinsky, 1993), thereby increasing their dependence on indoor life (Inoue & Matsumoto, 2001).

Ghana is yet to develop holistic measures that could adequately address the needs of both persons with disabilities and older people as distinct groups, and uniquely for older persons with disabilities. For example, although the Persons with Disability Act was passed in 2006, a legislative instrument has not yet been developed to operationalize the Act, nor has the Act been harmonized to align with international laws. On the part of older persons, although there is the National Ageing Policy (2010), more work is required to enforce its implementation to

give older persons in Ghana a better quality of life. Undoubtedly, age-related challenges could adversely worsen the plight of older persons with disabilities, thereby requiring conscious and concerted efforts to provide better living conditions for older persons with disabilities. In summary, as the number of older persons continues to increase worldwide, so would the population of older persons with disabilities. Older people with disabilities would require unique care arrangements and support to mitigate the compounded vulnerabilities that the intersection of ageing and disability present.

Guided by the theory of intersectionality, the life-course theory of ageing, and the social model of disability, content analysis and personal conversations, this paper explores the vulnerabilities and needs of older persons with disabilities in Ghana and provides recommendations to address their unmet needs.

Definition of terms

- In this paper, persons with disabilities (PWDs) reflects the persons first language and the definition by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full-effective participation in society on an equal basis with others" (p. 4).

- Older adults are those who are 60 years and above. Sixty years in the retirement age in Ghana.

Theoretical Framework

The theory of intersectionality, the life-course theory, and the social model of disability guided this study. In combining these theories as a framework for the study, it is anticipated that issues resulting from the interaction of disability and ageing would be highlighted.

The theory of intersectionality was proposed in 1989 by a feminist legal scholar, Kimberle Crenshaw, who argued that single categorization of discrimination based on race, gender or any minority groupings could systematically omit the experiences of the more vulnerable groups. The proponents of intersectionality call for a re-examination of the definition of oppression to include the experiences of those who fall within multiple categories of vulnerabilities, such as ageing and disability. Exploring the intersection of ageing and disability is critical, as older persons with disabilities could experience vulnerabilities which stem from both the disability and old age. For example, aged individuals with disabilities will have significant health and financial problems commonly related to age, which require the support of additional services and resources, or which require the services of caregivers (Larkin et al., 2003). Unfortunately, professionals in ageing often lack knowledge about disability issues, while professionals in the field of disability often know little about ageing. Furthermore, intersections of ageing, disability, and factors such as gender, socio-economic status, presence, or absence of family support ought to be explored to comprehensively understand the lived experiences of older persons with disabilities in Ghana, and to understand the nexus at with care arrangements and supports should be developed.

Another lens through which this study seeks to understand the needs, opportunities, and challenges of older people with

disabilities is the life-course perspective. The major tenets of the life-course perspective are that people's lives are unveiled over time, and that circumstances and events which occur in previous stages of life have lasting effects later in life (George, 2019). For example, acquiring a disability at an early age in life has long-term implications for the individual at the various phases of his or her life. This perspective examines developments in a person's life extending from birth to death (Komp, 2016). Inarguably, the risk of acquiring various kinds of impairments increases as people grow older (Jeppsson Grassman & Whitaker, 2013) and coupled with events in people's lives and the decisions they make, these events usually have a bearing on one another (Komp, 2016). Since individuals are exposed to different opportunities, constraints, and preferences (Komp, 2016), experiences of marginalization or discrimination would vary from one person to another. For instance, people who acquired disabilities earlier in their lives would have different lived experiences from those who acquire disability because of ageing. These are nuances that the study seeks to explore in connection with the unique care needs and supports required by older persons with disabilities in Ghana.

Additionally, the study employs the social model of disability to help appreciate barriers and facilitators in the Ghanaian society which create disabling environments for older persons with disabilities. Disability, according to the social model, is all the things that impose restrictions on people with disabilities, ranging from individual prejudices to institutional discrimination, from inaccessible public buildings to unusable transport systems, and so forth (Oliver, 1996). For example, while there might undeniably be physiological conditions which would require medical interventions, "empirical research on the role of the workplace, community, social networks, and cultural attitudes and beliefs is increasingly demonstrating the significant role that the environment plays in shaping life experiences of people

with physical impairments" (Putnam, 2002, p. 804). According to Putnam (2002), the social model of disability is useful in helping to make clear distinctions between physical impairment which is a personal characteristic; functional limitation, which refers to the person's ability to perform an activity regardless of the situational context; and disability, which is the situational variable. The social model of disability therefore highlights how an inaccessible environment for example, creates a disability for an individual with a physical impairment, thereby removing the responsibility of participation or otherwise from the person. The experiences of older persons with disabilities will be explored through these lenses as well to help understand their lived experiences in relation to the environments they live in.

Using the theory of intersectionality, the life-course perspective and the social model of disability, the experiences of older persons with disabilities will be explored to draw out societal and environmental barriers which impact older persons with disabilities in Ghana and the opportunities available for designing and developing lasting interventions.

Method

Content analysis and personal conversations were utilised in this study. The researchers held conversations with two individuals, a social worker, and a service provider. For the content analysis, 15 organisations were sampled from three sources (1) google search for agencies providing services for the elderly in Ghana, (2) the database of the field practicum of the Department of Social Work of one of the universities, and the Centre for Ageing Studies at the University in Ghana. All the organisations were private. Out of this number, a third (n=5) were non-governmental organisations (NGOs), and the rest were for-profit. Out of the NGOs providing elderly care, one agency operates from a foundation borne out

of corporate social responsibility. The rest depended on the generosity of philanthropists and volunteers to provide free care for the elderly. Ten of the agencies operate for-profit, but none of them was accredited to accept payment under the National Health Insurance Scheme (NHIS), which aims to guarantee access to healthcare for all Ghanaian residents.

Results

The results indicate that there were no systematic and coordinated care arrangements for elderly persons in Ghana, although private and government agencies provided services.

Private services

The study revealed that home care, healthcare, respite care, transportation, and other services were provided by the private agencies sampled. Both the NGOs and for-profit agencies provided home care. However, home care services provided by the NGOs were basic services to help the elderly manage life at home. These services included personal care, homemaking, and home management, which were identified as challenging for the elderly because of the decline in functional ability and health issues (Braimah & Rosenberg, 2021). Besides the above home care services, the for-profit agencies offered recovery home care, live-in, sleep-in, live-out and waking night services and day care services. Trained specialists provided homecare services offered by the for-profit agencies, including nurses and other professionals, whilst many NGOs engaged volunteers.

Also, healthcare services provided were geared toward the physiological well-being of the elderly consistent with the life-course theory (George, 2019). The NGOs mostly organised

occasional free medical screening and medication for the elderly. They also assisted elderly persons with their hospital appointments and other medical-related errands. The for-profit agencies provided a range of healthcare services, including in-hospital personal care, home care/nursing services and recovery care at home services, medication administration, monitoring, and other healthcare services such as physiotherapy.

Given that most Ghanaians 60 years and over live in poverty (Gyasi, Phillips, & Buor, 2020) and not all of them are eligible for the NHIS (Braimah & Rosenberg, 2021, WHO, 2014), it implies that few of them could afford healthcare services provided by for-profit organisations. Similarly, the association of disability and poverty is emphasised in the literature (Mitra, Posarac & Vick, 2012; Mizunoya & Mitra 2012, WHO, 2011) and not all persons with disabilities are covered under the NHIS (Naami & Nfoafo-M'Charty, 2020). Therefore, the intersection of disability and ageing could complicate the healthcare experiences of elderly persons with disabilities.

Further, the results suggest that respite care is mostly provided by for-profit agencies. This type of service offers temporal home or institutional care for the elderly, providing relief for their usual carers. Respite care is an essential service for families of elderly persons because it enables them to engage in other things while care is provided for their loved ones. Also, elderly persons can mingle with their peers, thereby reducing the isolation or boredom that characterises their experiences (Braimah & Rosenberg, 2021). Further, it is noteworthy that three agencies, one NGO and two for-profits, provided residential services. However, the duration of this service was unclear, (i.e., short, or long term. Disability and ageing based poverty could impact the experiences of older adults with disabilities.

In addition, two for-profit agencies indicated they provided transportation services for the elderly. Transportation is important for everyone (Naami, 2019), most especially for the elderly, who have reduced ability to drive because of the decline in physiological functioning, increase diseases, the need for regular hospital visits, and to run their errands (Aboderin & Beard, 2015; Braimah & Rosenberg, 2021; Mudege & Ezeh, 2009). Out of the two agencies, only one was specific about the service provided; aiding elderly persons to run errands, go for regular hospital appointments, or engage in activities of their choice. The lack of transportation services for older persons could add a layer of vulnerabilities to those with disabilities since most public transportation systems are inaccessible (Naami, 2019; Tijm et al., 2011). Persons with disabilities mostly rely on taxis and other private services (Naami, 2019).

It is worth mentioning that only two out of the 15 agencies indicated that they provided services for persons with disabilities, and they are both for-profits. However, their target is not older persons with disabilities who have lived with disabilities for most or all their lives. Their focus is on age-related illnesses such as Alzheimer's, Dementia and Parkinson's disease and developmental disabilities (e.g., learning disability, Autism, Asperger's, and Global Developmental Delay).

Government services

Government services for elderly persons are few; NHIS and Livelihood Empowerment Against Poverty (LEAP). The National Health Insurance Scheme (NHIS), which was established from the National Health Insurance in 2003 under Act 650 guarantees free access to healthcare for the elderly by exempting them from paying premiums under the exempt category; "pregnant women,

indigents, categories of differently-abled persons determined by the Minister responsible for Social Welfare, persons with mental disorder, Social Security and National Insurance Trust (SSNIT) contributors and SSNIT pensioners, persons above 70 years of age (the elderly) and other categories prescribed by the Minister" (Government of Ghana, 2020, p 20). There is evidence that not all older persons are eligible for the NHIS, and not many health problems are not covered (Braimah & Rosenberg, 2021, WHO, 2014). Likewise, not all persons with disabilities benefit from the NHIS neither are their mobilities aids covered (Agyire-Tettey et al., 2019; Naami & Nfoafo-M'Charty, 2020). The intersection of disability and ageing could complicate the experiences of older adults with disabilities.

The Livelihood for Empowerment Against Poverty (LEAP) programme is a cash transfer social protection programme (Government of Ghana, 2020). LEAP benefit is an area of concern as the floor benefit (GH₵64, approximately US$10.35) seems woefully inadequate to address the needs of the elderly. The eligibility criterion "person with a severe disability with no productive capacity" also means that the LEAP does not cover all persons with disabilities who are poor (Agyire-Tettey et al., 2019; Naami & Nfoafo-M'Charty, 2020). A personal conversation with Madam Kay, a social worker (A. Kay, personal communications on March 5th, 2022), indicates that older persons with disabilities may benefit from the District Assembly Common Fund (DCAF) for persons with disabilities. The DCAF is the only social protection programme that specifically targets persons with disabilities to minimise poverty, especially for those in the informal sector (National Council of Person with Disabilities, NCPD, 2010). Madam Kay stated that a key family member of the older person with a disability is empowered with an income-generating activity to enable them to provide for the older person with a disability.

Conclusion and recommendations

Older persons with disabilities would require unique care arrangements and support to mitigate the compounded vulnerabilities that the intersection of ageing and disability presents. However, as evident in the findings, there is no specific intervention geared towards elderly persons with disabilities. There is a need to conscientiously make provisions for the elderly persons with disabilities to provide for their unique needs arising from the intersection of ageing and disability. Considering this, we recommend the following interventions: medical care, home and daycare services, a government unit to coordinate issues of the elderly with disabilities, inclusion in decision making and future research.

Medical care

Given the high disability/health-related expenses (World Health Organization, 2016) and expenses relating to ageing (Aboderin & Beard, 2015; Braimah & Rosenberg, 2021; Mudege & Ezeh, 2009), it is recommended that the government support the health expenses of elderly persons with disabilities. This could reduce the burden of care for older adults with disabilities and their families and poverty among elderly persons with disabilities. The government could also establish hospitals or units in existing hospitals that could address the special needs of the elderly arising from old age and disability. The specialisation of care for the elderly, just as for children (paediatrics) could help address age-related health challenges which general practitioners cannot adequately manage (Ashirifi, Karikari, & Adamek, 2022).

Homes and day care services

Public or public-private partnership daycare centres are necessary for elderly persons with disabilities. The two personal conversations suggested that this intervention could engage the elderly, especially those with disability whose experiences over the life course is characterised by stigma and discrimination (Avoke, 2002, Naami, 2015; Ocloo, 2005; Slikker, 2009) and the prevalence of neglect of the elderly persons due to several factors including urbanisation/migration/poverty breakdown of the family system (Dako-Gyeke, 2014; Kpessa-Whyte & Tsekpo, 2020; Mudege & Ezeh, 2009). The state has one institution for the elderly and other vulnerable people in the Ashanti region of Ghana, the Bekwai Destitute Infirmary. The infirmary is said to be in a deplorable state (Joy News, 2018). Should this institution be revamped and staffed with interdisciplinary professionals to address the needs of elderly persons with disabilities?

Government unit to coordinate issues of the elderly with disabilities

A unit to coordinate all services for elderly persons with disabilities is necessary given the numerous barriers that they encounter daily. Wrap-around services could minimise the daily struggles of elderly persons with disabilities relating to inaccessibility/limited access to the physical environment, transportation, and information (Badu, Agyei-Baffour & Peprah, 2016; Mills, 2018; Naami, 2019; Naami, 2015; Tijm, Cornielje, & Edusei, 2011).

Inclusion in decision making

Elderly persons with disabilities must be included in decision making, especially those that concern them. This is because

they are expert knowers of their lived experiences and could best help design interventions that could address their needs. Stakeholders must make efforts to ensure that elderly persons with several types of disabilities, including women, are part of the decision making to help identify their unique needs and facilitate interventions that could effectively address those needs.

Future research

More research is required to understand the dynamics of the unique daily experiences of older persons with disabilities. Understanding their experiences relating to family life, healthcare, social relationships, material, and psychological well-being could enable social workers and other stakeholders in Ghana to position themselves to embrace the challenge and collaborate to improve the lives of older persons with disabilities in the country.

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Old Age: A Painful Transition in Ghana

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Abstract

It is argued that old age is a sign of wisdom, and that the older one becomes the more knowledge one acquires. This makes old people, and older women in particular a "learning institution" for the younger generation. No wonder that in some societies, it is a privilege to get older. Ideally, old age is expected to be revered and celebrated. Unfortunately, this is not always the case for many old people, and especially old women. On the contrary, many older people are exposed to different kinds of indignity including witchcraft accusations. Much of the extant literature on aging focus one form of transition; the transition from a "youthful" to an "elderly" age in ordinary social life. This article takes a different analytical approach to aging transition. Based on fieldwork conducted in northern Ghana, we use the eclectic approach to discuss three forms of transition of elderly people: (a) transition from home to the "witch camp" (b) ritual incorporation and living through life as a morally compromised strangers (c) becoming ill, dying and assuming the status of the "forgotten dead." This paper goes beyond exposing the "mystery of old age" to document the painful experiences of elderly women who have been accused of witchcraft and have passed through these transitional stages. Drawing on ethnographic observations, life-history interviews with accused witches and (in)formal conversations with other locals, this work raises perplexing questions regarding why old age is a painful

and regretful transition, especially for old women in relation to witchcraft accusations.

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Introduction

The essential roles played by the elderly in the Ghanaian society are institutionalised and unambiguous. These multifaceted roles are numerous to outline in this brief introduction. Culturally, the elderly ensure that the extended network of family is maintained and strengthened. This is demonstrated in their essential role in, for instance, child fostering practices. Among the Baatombu of northern Benin, for example, aside serving as foster parents, the elderly, as grandparents, take on additional responsibilities, including financial obligations (Alber, 2004). For Baatombu grandparents, Alber (2004: 28-29) notes: "not only do they feed, clothe and raise their grandchildren, but also find them a husband or wife and pay for their wedding". Hence, "fostering means that the grandparents take on the position of parents…." Fostering roles played by grandparents are reinforced by the essential informal social safety network role of the extended family in crisis situations.

The political roles of the elderly extend beyond being good mediators in conflict situations and advisors in certain chiefdoms, to practically demonstrating their traditional leadership acumen as chiefs, priestesses of certain shrines and as Queen mothers (MacGaffey, 2013; see also Odotei, 2006 in Sossou & Yogtiba, 2015). Among the Dagbamba of northern Ghana for instance, the essential political role played by the elderly is demonstrated by the reservation of certain chieftaincy titles for the daughters of the Ya-Na (paramount chief of the Dagbamba). Known as *Nabipuginsi*, these royal women occupy the Gundogu and Kpatuya

chiefdoms (Mahama, 2004). Ibrahim Mahama (2004) identifies other important *nam* (chieftaincy) communities reserved for women who are descendants of the Ya-Na to include, among others, Yiwogu, Warigbani, Fuyaa, Kugulogu and Shilung,. These communities, according to Mahama, are occupied by elderly women because of preference accorded older persons in Dagbon. Hence, as part of the requirements to rule these communities as chiefs or priestesses, occupants need to pass their menopause. This unique position accorded elderly women is not for window dressing purposes. What is clear is that these women chiefs have, over the years, demonstrated good leadership, especially in conflict management, mediation, and resolution. Mahama (2004, p. 21) surmises thus "Dagomba women chiefs are not merely titleholders but chiefs of substance". They are of chiefs of substance because "They have towns and subjects under their control." Added to these, "They have courts and administrative set ups" as well, and "They sit in State to receive their Elders and subjects. In short they are rulers." Reference to Dagbon is important because of the location of majority of the alleged witches' camps in the Dagbon traditional area. However, despite these traditional political roles, many people are ignorant about the political position of elderly women in Dagbon, and the role played by elderly women within the political sphere across Africa in general. However, admittedly, it is quite clear that beside these important political roles, and admission by society to this effect, a large section of women, and elderly women for that matter, remain politically underrepresented.

Economically, elderly women keep local rural economies running, especially serving as subsistent farmers, and crop and vegetable farmers. The economic roles also extend to serving as marketers and distributors of goods and services albeit on a small-scale. These "uncompensated activities" (Sossou & Yogtiba, 2015) are however problematic because even though important, many of

these types of work are often not captured in official statistics. Therefore, the elderly is the most economically excluded and materially deprived. Also, since the elderly are found in informal local/rural economies, they lack pension benefit to enable them to live dignified lives. This is compounded by the fact that "in most countries there is an emphasis on paid employment as the basis for pensions and welfare systems; for example, contributions systems are organised through employers" (Vincent, 2003, p. 23). In this sense, and "given the characteristics of the workforce in the modern sectors of the global economy, women, old people and those living in rural areas are the ones most systematically excluded" (Vincent, 2003, p. 23). Despite these challenges, their essential roles in local economies cannot be underestimated, and hence should be acknowledged.

It is in the light of the multifaceted roles played by the elderly that they are expected to be revered and adored by society. They may be seen as pots of wisdom. Based on this, Musah (2020) asserts that "possessed with wisdom, garnered through years of experience, old people are most often classified as the wisest in society, even though wisdom does reside in the old". This is akin to what Aubel refers to as the elderly being a "learning institution" (Aubel, 2005 in Quarmyne, 2011). Hence, the younger generation is expected to draw lessons and experiences from the elderly via storytelling sessions, babysitting songs, and funeral dirges. These experiences and lessons are partially gained from many years of work and toil, in the informal sector.

Depending on the context and the perspective in which aging is considered, it is not farfetched to contend that aging or old age projects an ambivalent mix of happiness and depression, optimism and hopelessness, regret and contentment, confidence, and self-indictment. This article explores the social implications of aging among women in northern Ghana. It discusses the

regretful experiences of women as they encounter aging, and especially at it relates to witchcraft. In doing this, we aim to go beyond the usual scholarly discussion of old age in ordinary social life. We document and analyse the practical encounters of old women as they transition through three distinct stages of "witchcraft indictment": transition from home to the "witch camp," ritual incorporation and diachronic living realities in the "camps," and transition to the stage of the "forgotten dead."

What is the problem?

Isn't it a compelling paradox that despite the essential roles played by the elderly, especially elderly women, they are wantonly deprived of necessities of life, and are sometimes shun by society? In one breadth society adores the appropriate roles of the elderly. In another breadth, society is silent about the numerous indignities confronting the elderly in the Ghanaian society. These indignities are wide ranging and multifaceted. This article is about the experiences of elderly women as they pass through three different transitional stages in life. Witchcraft accusations (which is often linked to the first transition - that is, transition from home to the alleged witches' camps) results in the natural emergence of the other two transitions. These are ritual incorporation and diachronic living realities in the "camps," and transition to the stage of the "forgotten dead." Majority of these so-called "witches' camps," which have disproportionate representation of women, and older women, have been in existence for many centuries, but have, in recent years, received widespread condemnations. Accused elderly women often face different forms of sanctions including banishment. Once accused, the elderly is ostracised by their communities and abandoned or stigmatised by their family members (sometimes including their biological children).

The disproportionate representation of elderly women in the camps, compared to men, highlights what is described as the feminisation of witchcraft (Musah, 2020; see also Crampton, 2013). Feminisation as a concept, is used to describe the female angle or face in many socio-economic and political discourses. It was originally used to describe a large segment of women living in poverty. This concept is extended to explain the gender dimensions of witchcraft beliefs and practices. Hence, feminisation of witchcraft simply indicate that witchcraft accusation (or victimisation) has a 'female face'" (Musah, 2020, p. 163). This feminisation is practically manifested in the Ghana's "witches' camps," as women inhabit them. During the time of our fieldwork in 2015, 2016 and 2017, all but one "camp", were inhabited by elderly women. This is unsurprising because belief in and the practice of witchcraft across the globe is or remains an "older woman's problem" (Crampton, 2013, p. 199). What should be noted is that accusations against older women are systematic and "institutionalised." What is clear is that, often, once eyebrows are raised regarding witchcraft, old women become uncomfortable as they are the obvious targets for accusations and victimisations.

Witchcraft beliefs, accusations and persecutions are widespread in West Africa. In Ghana, stories of witchcraft accusations and grotesque maiming of elderly accused witches are often reported in newspapers. These stories show the extent to which old age could lead to distrust and hatred. In 2010, a 72-year-old woman, on suspicion of being a witch, was killed in the industrial city of Tema in Ghana (Adinkrah, 2015). Also, in 2017, the people of Trindongo in the Upper East region murdered a 67-year-old woman in cold-blood on suspicion of witchcraft. The woman in question was stoned to death (Danyo et al., 2018). In July 2020, a video that showed the murder of the 90-year-old Mariama Akua Denteh went viral. In the video, two young women, surrounded

by onlookers, were seen maiming the elderly woman. Unable to bear the torture, Akua Denteh passed on.

The above cases highlight several important things. First is the gender aspect. Although men are sometimes accused, majority of those accused and persecuted are women. Secondly and relatedly, it is not merely about the issue of women, but elderly women. This directs our anthropological gaze to the dynamics of aging and elderly people in northern Ghana. The article raises three critical transitional issues of aging by the elderly, in relation to witchcraft allegations. These are transition from home to the "witch camp," ritual incorporation and living through life as a morally compromised being and becoming ill, dying and assuming the status of the "forgotten dead."

Method

This paper is partly based on data derived from our doctoral field projects conducted between 2015 and 2017. The fieldwork was done in local settlements in northern Ghana variously described as "witches colonies," "witches' settlements," "outcast homes," or "witches' camps." Although the projects did not focus exclusively on the elderly, the life worlds of the elderly constituted a central part of these works because "witchcraft beliefs are a part of everyday life in Ghana and a part of aging in Ghana as well (Crampton, 2013, p. 199).

In view of the culturally sensitive nature of the research, appropriate research methodology which responds to changing local dynamics was used. This was necessary because "witchcraft beliefs and practices are complex processes with interlocking explanations and assumptions" (Musah, 2020, p. 136). Hence, to be able to understand various local or micro-level processes which relate to witchcraft beliefs and practices

concerning the elderly (as well as to contextualise them), the insertion of "self" into the world of the research participants (ethnography) was indispensable. This methodological approach created an atmosphere that enabled us to dig deeper into participants' lifeworld, especially their feelings, aspirations, and understandings of the various transitions.

As part of the ethnographic engagement, more than fifty (50) accused witches were interviewed while life-history interviews were conducted for the *magazianima* (women leaders) in all the six well-known "witches' camps". In addition to these, we also conducted interviews with local *asanza niriba* (opinion leaders) as well as Church and Non-governmental Organisations (NGOs) officials who had working relationships with the elderly accused women in these settlements. All these were supplemented by both participant and non-participant observations as well as informal or casual conversations and interactions.

Given its slippery and culturally sensitive nature, the subject of witchcraft could best be explored ethnographically through the deployment of the native language. The appropriate use of native language (and the etiquette associated with its usage), could determine the level of openness of research participants. Hence, our competence in speaking the Dagbani language, which was spoken by many of our research participants, was helpful in the data collection, and indeed the entire fieldwork process. Our demonstrated competence in Dagbani also ensured that we obeyed basic etiquette of the Dagbamba. Among the Dagbanmba, respect accorded to people of higher status is valued. This is demonstrated by lowering one's body and going down on one knee (women go down on two) (Salifu, 2010). Interestingly, Salifu's observation reaffirms the kind of veneration accorded the elderly in Dagbon society.

Transition to "witches' camp" and derision of old age

What accounts for witchcraft accusations against elderly women? Who are the main architects behind these accusations? How is the transition from ordinary homes of accused persons to the "camps" done? Attempts are made to answer these questions in this section. We begin by arguing that the causes of witchcraft accusations are many and varied. However, because of limited space, we concentrate on the role of the youth within the transition from home to the "camps."

Unsuccessful youth

In Ghana, the causes of witchcraft accusations against the elderly are broad and multifaceted. Like in many other jurisdictions, the youth are at the centre of accusations. During fieldwork, many of our research participants (accused elderly women) noted that they were accused by young people, especially young men. The youth were also said to be at the centre of witchcraft-related violence and destruction of properties.

The many long interviews held with our interlocutors during fieldwork revealed that witchcraft suspicions and accusations are inextricably linked with old age. Having attained an advanced age and looking weak and frail, the elderly was unable to "fight" back when they were physically assaulted. During our interviews in Kukuo, we met Memuna, an elderly accused woman. She could not mention her age, but her physical outlook gave us a clue about her age; she was in her eighties. Interestingly, even though Memuna did not know our ages, she claimed that she had been living in Kukuo before our birth. Given that we were both in our late-30s, Memuna's claim meant that she had probably been living in this settlement for more than forty years. Several decades ago, Memuna was accused by a young

man in her original village. Her accuser was a school drop-out but was doing well in trade. The young man accused her of being responsible for his drop-out and the frequent illnesses he suffered. He also accused her of stifling his trade and blocking his general prosperity. The accusation shocked Memuna. Her own children, three males and two females, were also not progressing economically. "Am I responsible for their predicament as well?" She asked rhetorically. Interestingly, neither her late husband nor any of her children supported or protected her. She received several threats of harm from her accuser. The community members supported the young man and chastised Memuna for allegedly bewitching him.

One early morning, as Memuna was preparing to move out to fend for herself, two angry and incensed young men accosted her. Before she could say a word, one of them knocked her on the chin. They threatened to kill her if she did not leave the community immediately. Memuna panicked as other locals started gathering and forming a crowd around her. She was deemed morally compromised and had lost community support. Fearing that she could be subjected to more harm, she moved out of the house, and made her way to one of the alleged witches' camps (Kukuo). During a long interview with Memuna, she described Kukuo as her "permanent home" and the host community members as her "family." She recalled with pain how both her late husband and biological children looked unperturbed as she fled her natal home to finally settle in Kukuo. But Memuna did not blame her children much because of their apparent powerlessness. "The Devil finds work for idle hands," Memuna noted. She mentioned that her attack by the youth only signified a transfer of youth irresponsible behaviours. They failed to extend care and support to her as custom demanded. Aboderin (2004) reduces this kind of behaviour to two key words: "unwillingness" and "incapacity". That is, the unwillingness and incapacity of the youth to support

the elderly as customs and moral ethos demand. Hence, the "increasing *unwillingness* of the young to provide for the old" and the "growing *incapacity* on the part of the young" to extend care and support to the elderly (Aboderin, 2004, p. 129). For Aboderin, care and support for the old by the youth are discretionary.

In 2016, during one of our encounters with accused witches, we met Adiha (not her real name). She lived a lonely and unhappy life back in her original community. She was considered insignificant within the household because her people viewed her as an economic burden. Adiha felt that she was not accorded the kind of respect she deserved as mother and grandmother to several children. The lack of respect brought about low self-esteem. Adiha was therefore not surprised when her own family members accused her of bewitching her granddaughter. The accusers ignored the fact that Adiha personally contributed to nurturing her grandchildren. She was accused regardless of her role in "building family bridges." Adiha's story is symptomatic of the sheer disregard for old age by the youth.

From the stories we documented, it was clear that the elderly was blamed for the failures of the youth to make progress in life. From the perspective of the youth, the elderly "witches" were denying them the benefits offered by modernity. This kind of discourse is like Fisiy and Geschiere's (2001) work which focuses on witchcraft being adopted as an active resistance against modernisation and development. It also resonates with Comaroff and Comaroff's (1999) piece on witchcraft being used to provide answers as well as interpretations to unequal rewards and aspirations during uncertainties and moral disquiet associated with modernisation and development. One can also extend this to Englund's (2001) work which views witchcraft as a tool being deployed to confront modern and development-related problems in both urban and rural areas.

During fieldwork, we noted that anytime questions were raised regarding the youth, many participants wore visibly irritated faces. Some women poignantly noted that instead of depending on the youth at this critical and vulnerable stage of their lives, they felt betrayed by them. During an interview session in Gnani, Mungani (not a real name), an elderly male accused witch, indicated that in *Dagbon kurili* (ancient Dagbon), living with elderly persons constituted a sign of respect and favour. He remarked with pain,

> *This world has changed. Nothing is certain these days. The youth have been influenced by many modern things. There is total disregard for elderly people in our communities. May be the youth think that they have made it in life, or they have become more civilised than those who gave birth to them. They don't attach any respect to the elderly. They insult and point fingers in their faces without fearing anything. This didn't happen in ancient Dagbon. Those days it was considered a favour and privilege to live with an elderly person, and family members did everything to protect their elderly people. Our values have increasingly eroded. We don't value the elderly anymore. It is sad*.

Mungani fled to Tindang (the name of the local "witch camp" in Gnani) 14 years earlier when his senior brother's son, Ganeem, accused him of witchcraft. Ganeem had just completed his teacher training programme in one of the teacher training colleges in Tamale and was preparing to commence his teaching career. The young man's dream was, however, cut short when he fell seriously ill. The illness, which family members believed had no biomedical cure, lasted for about a month. When there were no signs of recovery, Ganeem accused Mungani of being envious of his success. Ganeem died few days after the accusation. Before he died, Ganeem succeeded in convincing his father

that Mungani was responsible for his affliction. After his death, Ganeem's siblings mobilised the support of the local youth to chase Mungani out of the village. Mungani was 61 at the time he fled the village. He was well received by the Tindana at Gnani who assured him of his safety.

Throughout our conversation, Mungani lamented about the moral decadence that has taken hold of modern society and its consequences on the relationship between the youth and elderly people in society. For him, law enforcement agencies are partly to be blamed for the derision of old age by the youth especially in relation to witchcraft accusation and victimization. "If they beat or kill an elderly person because of witchcraft and the police are able to deal with them ruthlessly, they will learn a lesson and will dare not repeat it," Mungani noted.

In many of the confrontations involving the elderly and the youth, the later considered their actions as acceptable and appropriate behaviours because the accused were believed to have violated laid down traditional or customary expectations which centred on good behaviour and conduct. Hence, the youth considered their actions to be legitimate. It showed "collective disapproval and indeed resentment of suspects' seeming 'immoral' scourge" (Musah, 2020, p. 202). Baba Iddrisu Musah (2020, p. 202) argues that in the case of physical violence, the actions by the youth are "seen to be plausible to communal members who see the actions and activities of suspects as threats to communal life…,". In the specific case of physical overt violence (and its justification), it fits into Sally Engel Merry's (2006) classification of gender violence as "appropriate violence" or "acceptable violence". Appropriate violence in the sense that it is considered "appropriate discipline for certain kinds of behaviour" (p. 25). Often, the assumption is that violence perpetrated is considered to fit the "crime" committed, and hence to suppress the "crime": witchcraft-

related deaths, diseases, and illnesses (Musah, 2020). As Gibbs (2012) argues, "the core purpose is to protect the community from the perceived threat of witchcraft". What is to be noted is that these assumptions may appear unscientific. But what is "science"? And does it even matter to the youth? Absolutely not. No rational or logical reasoning and/or explanation will convince incensed communal youth to shift their positions or change their minds when they feel that the social order has been compromised and disrupted by immoral "witches." For Adam Ashforth (2015, p. 7), witchcraft raises "a very different issue of justice, one that goes beyond the simple problem of false accusation and involves harm done by witches to their victims". From this perspective, Ashforth (2015) noted, "Perpetrators of witchcraft…are dangerous and powerful figures, not members of vulnerable groups, however frail seeming they may be. Witches are said to cause illness, death, suffering, and misfortunes of all kinds. Proceeding on the conviction of local justice, witches are "perpetrators of criminal violence, albeit of a particular kind. For people who live in the world of witches, their primary concern has to do with security. Hence the dangers posed by witches are present and real (Ashforth, 2015).

During fieldwork, it was observed that the way local accusations of witchcraft were often managed did not help matters. Youth violence against elderly persons accused of witchcraft was reinforced by delayed actions on the part of traditional authorities. Accusations were often accompanied by heightened expectations of quick resolution, especially by traditional authorities. Delayed response to accusations raised eyebrows and affected prevailing trust between the youth and community elders. As Musah (2020, p. 201) notes, "By staying arm's length from the activities of suspects, traditional authorities, and chiefs for that matter, are believed to build walls of silence behind suspects' alleged activities or machinations, and of witchcraft

practices in general, and this might imply indirect and tacit approval of suspects' actions". Musah's work further highlights that traditional authorities' delay in handling witchcraft-related accusations and persecution denotes "indirect, sympathetic and sometimes compassionate acceptance, accommodation and indeed approval of the alleged activities, machinations, and intentions of suspected witches" (Musah, 2020).

Traditional justice mechanisms and processes

Once an elderly person was accused of witchcraft, there were various mechanisms of seeking redress. The commonest mechanism (and the one used frequently) was seeking redress from traditional authorities (*kpamba/kpambalba*) or local chiefs (*nanima*, sing. naa). Headed by *nanima*, it was the responsibility of traditional authorities to find an amicable solution to the witchcraft crisis. This was part of the politico-judicial functions of *nanima.* As Hangmann (2007) once noted, "resolving conflicts represents a 'chiefing' activity of special importance". Emphatically, "traditional leaders have often asserted their authority informally in carrying out state functions in local political settings, such as dispensing justice, collecting rent, and policing" (Kyed & Buur, 2007, p. 2). This was like the role of chiefs in precolonial times. In precolonial times, chiefs "ruled as the political heads, their palaces were the courts where disputes were settled and justice was administered" (Assimeng, 1999). The central role of chiefs in the management of witchcraft accusations is essential because accusations are often accompanied by communal tensions and divisions. Hence their involvement is primarily intended to prevent scale-up of communal tensions, (Musah, 2020). Among the Dagbamba, a visit to the chief's palace was often preceded by attempts by the *dogrikpema* (head of a family) to find an amicable solution to the witchcraft-related crisis. This was intended to prevent family rapture.

Among the Dagbamba, resolution of witchcraft-related crisis was built around the council of elders in a community (made up of the *Naa* and his *kpambalba*). This was an admission to the significant role played by the elderly in dispute resolution in Dagbon. "This explains the reason why the council of elders constitutes an important pillar, and thus is commonly consulted on matters which come to traditional authorities" (Musah, 2020, p. 232). Writing on the Dagbamba, Mahama (2004, p. 83) notes that they spend the longest time with the *Naa*, and that they ensure that there is continuous flow of information and humour.

Interestingly, many of our interlocutors noted that they mistrusted traditional rulers because the likelihood of being found guilty was often high, even though they could genuinely be innocent. According to the informants, arbitration became even more problematic and biased when the accused involved is an "elderly woman." In Nabuli (one of the six famous "witches' camps" in the Gushegu district), during an interview with Sabul, an accused woman believed to be in her late 70s, she commented,

> *Elderly women are most susceptible to witchcraft accusations in our local communities and are most likely to be found guilty when brought before the chief for interrogations. We are powerless and therefore can't argue with the chief, whether we are right or wrong*.

The mistrust between accused elderly women and local mediators, and especially the denial of voice (arising out of power asymmetry) in the court of the *Naa* sometimes compelled human rights activists to question fairness and neutrality of local mediating agents. Concerning the issue of mistrust, one interlocutor (an elderly accused witch) noted:

> *I refused to go to the chief's palace because I know I was not going to be successful. He has never listened to an alleged witch. He*

> *always supports the youth when they send you there. The best place to move to is this place ["witches' camp"] where I am a bit free.*

The assertion above is like Musah's (2020, p. 236) finding in one of the "witches' camps". One of Musah's research participants noted: "The chief was the worse. He stood firmly behind the accusations. When I wanted to speak, he shouted me down and said that he was the owner of the land and therefore decides what is good." This highlights suppression of expression and curtailment of fair hearing. In the end, suspects remain voiceless (Musah, 2020, p. 236). Elderly accused persons often feared that they would be found guilty before an intervention. The idea of traditional rulers and their councils remaining neutral in the resolution process was questionable.

Mistrust, suppression of expression and the likelihood of being ostracised resulted in accused elderly persons moving to nearest alleged witches' camps. Beside these, others moved to the "camps" based on fear of being physically attacked and/or abused. Others were also sent there by their family members to prevent a seeming breakdown of family unity with accusations at the centre.

Ritual incorporation in the "witches' camps"

Our discussions in the preceding section focused on how accused elderly persons transition from their original villages to the "camps" upon witchcraft accusations. In this section, we aim to discuss a different form of elderly transition in life: ritual incorporation into a "new" home ("camp" environment) where the accused persons live and experience another form of life.

During our research, we encountered many cases where elderly accused people arrived in the "witches' camps" as morally compromised strangers. They were seen to be morally compromised in the sense that they had been rejected by members of their own families and communities who viewed them as immoral 'killers' and "racketeers" of social and public order. Regardless of the way they were expelled from their communities, newly arrived elderly accused persons were required to subject themselves to the necessary bewitchment processes to get their witchcraft powers expunged. Ritual cleansing by the *Tindana* (earth priest) was the most important requirement for admission into the "witch camp," and this was non-negotiable. Ritual cleansing was considered very crucial because it provided a platform for the accused person's *sotim* (witchcraft powers) to be expunged. Such an action increased social acceptance of accused elderly persons by the host community because it reinforced the psychological feeling that the accused had become harmless to society.

In December 2016, during one of the field trips to Gnani, the local Tindana accepted our request for an interview. As typical of the weather in northern Ghana, the sun was unusually hot on this day. The Tindana agreed to meet us in an old summer hut erected in the forecourt of his house. Notwithstanding our discomfort about the presence of other locals in the hut who could hear our conversations, the Tindana was not bothered about this. As a local leader, he felt happy being surrounded by his people who frequently referred to him as "chief." In fact, he prided himself around this title. The conversation with the Tindana concerned the procedures for ritually incorporating accused witches into Tindang (the local name of the "witch camp" in Gnani). He started by saying that he does not perform rituals for accused people unless at least one witness of the client is present. He explained that the rituals performed are two

types: testing for witchcraft and cleansing of the "dirty powers" (witchcraft power). The conversation was long and frequently interrupted by family members and other locals who needed to "see" the Tindana. Towards the end of our conversation, three cars arrived. The Tindana paused the conversation and got up to see the visitors. He mentioned that the people were his visitors and that they had come for anti-witchcraft consultation. Later, the Tindana revealed that the visitors were from Tamale. Tamale is the regional capital town of the northern region of Ghana. It is also one of the most cosmopolitan cities in northern Ghana. They had been referred to him by the Choggu-Naa (a chief of one of the suburbs in Tamale) who received complaints about bewitchment.

The Tindana provided benches for the waiting visitors to sit on while he retreated into his inner chamber to prepare for the rituals. When he returned, the place was as quiet as a graveyard. Uncertain about the outcome of rituals yet to be conducted, the accused looked visibly worried. The Tindana then announced the following as the items required for the rituals: a chicken, *dam* (local beer) and an amount of 65 Ghana Cedis. The accused persons might have been briefed earlier about the requirement as each of them came with a chicken and money to cater for other ritual expenses. After all payments had been made, the Tindana led the visitors and other local community members to the shrine. The Tindana pointed to an abandoned, dilapidated house and said, "this is the *kali yili* [literally, customs house]." This structure formed part of the bigger shrine and was described by the Tindana as the territorial space where libation was poured to the ancestors and animals slaughtered for clients who came for ritual consultation.

In this instance, one of the visitors, named Baako (a middle-aged man), was accused of witchcraft by a young woman. Adinpuya

(the accuser) claimed that she had seen Baako in her dreams several times trying to kill her. Having listened to the accuser, the Tindana invited Baako to step forward to undergo witchcraft testing. This was meant to establish the guilt or innocence of the accused. Holding his chicken and looking visibly worried, Baako stepped forward and made his *pori* (a public declaration or oath):

> *My sister here has accused me of trying to bewitch her. She claims that I attack her every night, but I am not a bad man. I am innocent of this accusation. I use my tim [magic] to treat people and save their lives. If it is true that I am using my tim to harm her, may the shrine reject my chicken. If I am innocent, I beseech the shrine to accept my chicken and exonerate me.*

On completion of the *pori*, the Tindana took the chicken from him and started making libation using the *dam* bought by the accused. He recited incantations which involved invoking his *yaan'nima* or *kpiimba* (ancestors) to rise and separate truth from falsehood. Having completed the recitation, he cut off the chicken's head and allowed it to die. The sacrifice was meant for the ancestors who would help to establish guilt or innocence. Locals believed "that the chicken's contorting body could channel the ancestors' answer" (Mutaru, 2019, p. 70). After a while, the slain chicken died on its back (face up). This was interpreted as an acceptance of Baako's chicken by the shrine (or the ancestors).This was good news for Baako. His brother, who accompanied him (also as a witness) and was looking pensive and restless during the testing process began to smile after the verdict. The Tindana later explained that Baako would have been declared guilty of witchcraft if his chicken had died on the stomach (face down).

The above-described ritual was often the first process to be conducted to initiate or incorporate an accused witch into the "witch camp." Baako was one of the few elderly people who escaped "conviction" upon consulting the shrine. Because he was

declared innocent, he could go back home without provocation or attack from the local youth. An unlucky elderly person whose accusation was upheld or confirmed by the shrine needed to go through physical or financial ordeal to be accepted to live in the "witch camp."

Physically, an elderly person whose accusation was upheld by the shrine and who accepted to live in the "camp" to save her life needed to surrender to bewitchment or cleansing rituals by the Tindana. Apart from subjecting her body to a series of thorough rituals, the accused had to bear all the expenses involved in procuring the materials for the rituals. The elderly people would later confess that the requirements involved in the cleansing or incorporation rituals were difficult. While the major requirement (animal sacrifice) was common to all the anti-witchcraft shrines, the specific requirements varied from place to place. The Tindana in Gnani required a sheep and chicken to sacrifice for the ancestors to get the accused cleansed and accepted into the host community. However, at Kpatinga, the Tindana indicated that the shrine required goat, guinea fowl and chicken as sacrifices. At Gnani, an opinion leader revealed why the animal sacrifice was important: "Until this is done, everybody will continue to see the accused as *ninvu*ɣ'*be*ɣ*u* and will fear and avoid her."

At Tindang (Gnani), unlike other settlements, the ritual process was more cumbersome for newly arrived elderly accused persons. Here, they were confined to the *kali yili* (literally, "customary house") where they spent the night alone. The purpose of the seclusion is to "spiritually prepare grounds for ensuing activities" (Musah, 2020, p. 269). The next day, the accused was brought out of the *kali yili* whereupon the Tindana proceeds to perform the remaining cleansing rituals. As part of the ritual process, the Tindana poured some *dam* (local beer) on the ground in libation to the ancestors. The ritual animal (provided by the accused) was

then slaughtered as sacrifice to the ancestors who then spiritually partook of the animal. In Gnani, the Tindana mentioned that the slain animal's blood was collected with the soil and mixed with water to obtain the desired *buɣkom* (literally, shrine water). The "*Buɣkom* was believed to be a mystical and sacred portion sanctioned by the ancestors and therefore more powerful than the accused person's *sotim* [witchcraft power] (Mutaru, 2019, p. 91). To be accepted into the settlement ("witches' camp"), an accused had to drink the *buɣkom*. Locals believed that any accused who drank this had her witchcraft powers destroyed and she was rendered harmless to society. The cleansed woman could not bewitch anyone, and she could be killed by the ancestors any time she attempted bewitchment. The cleansing (incorporation) ritual was completed by having the accused woman's hair shaved. The belief was that the hair brought by the accused from her community was bad. To make the cleansing process complete the unkempt hair had to be removed.

Having completed the ritual purification exercise, the accused was now fully recognised as a member of the Tindana's settlement (so-called "witches' camp"), and members of the host community could now "trust" and live with her:

Everyday life in the "camps"

Entry into the world of the witches (and rarely wizards) was not an easy one. As typical of every traditional palace in Dagbon, one could not enter a community without the knowledge of traditional (spiritual) leadership. This was even quite fundamental for people, and especially accused elderly women who had been ritually incorporated into the alleged witches' camps for safety: spiritual and physical. Because the elderly women were considered as morally compromised and "misfits" in their communities, actions were undertaken to ensure that they were "fit" to live in their new homes (the "camps"). During

an informal conversation with the Tindana of Tindaanzhee at Kpatinga, he commented:

> *You cannot easily enter this settlement ["witch camp"]. Even if you are brought at night, they have to wake me up to come around and welcome you. I am the only person who can grant you permission to stay here, either temporarily or permanently. I have to conduct some spiritual cleansing before you are allowed to live here*.

As the above narrative shows, it did not matter what type of danger was at hand. Neither did it matter what underlying conditions propelled an accused witch/wizard to flee to the 'witch camp' – the incorporation ritual process was the same and had to be followed.

At the time of the fieldwork, old women inhabited all the six well-known "witches' camps" (except Tindang in Gnani). The population in Tindang was a mixture of elderly men and women. We recorded an average age of 58 (in Gambaga), 67 (in Gushegu), 71 (in Kukuo), 66 (in Nabuli), 61 (in Kpatinga), and 68 (in Gnani). Overall, the average age in all the "witches' camps" was 65 years. This age statistics show the kind of vulnerable people who inhabited the "camps." For most elderly women, it was difficult living alone without "helpers." This accounted for the relocation of young boys and girls to the settlements by extended family members who thought it wise to provide "maids" to the banished elderly women. Others already had fostered children, largely girls, staying with them, and hence these girls automatically served as "maids" to the elderly accused. Compared to their original villages, life was not better here, but the elderly women did not want to go back home because there was no peace (Crampton, 2013) at home. They preferred living in penury in the newly found settlements than facing death upon their return home. Their lives, many argued, were much secured

in the "camps" than their natal homes. Many were full of praises for the Tindana for ensuring that their physical security and safety were guaranteed.

In many of these settlements, the accused lived in tiny, dilapidated thatch houses without electricity. Some of the rooms had no doors, while others had leaky roofs, thus leaving the elderly accused women at the mercy of reptiles and rains during the rainy season. Musah (2020, p. 310) gives a graphical description of the thatch structures in the following words:

> *…Spaces which the huts provide are only enough to accommodate mats which many residents sleep on, a small space for personal effects which are few though, a location dedicated for cooking, especially during the wet season, and a portion (dug hole) meant for bathing. Like thatch huts, the doors of the huts are so low that residents are compelled to bend or stoop to enter into them. Besides this, most of the doors of the thatch huts are poorly maintained that they can easily cave in at the least touch.*

In Kukuo, for example, accused witches, with aging complications, had to trek several kilometres to the Oti River to fetch water. Old women who were lucky to have "maids" avoided some difficulties relating to chores as these "maids" provided the necessary help. We found that elderly women who had no "maids" and struggled with household chores were those who had been accused by direct family members (such as biological children). They were left alone to fend for themselves. They had been abandoned and shunned by people they birthed and nurtured. By these, witchcraft accusations and labels create walls, walls that serve as barricades, preventing the elderly from having any meaningful form of engagement with their families and other social networks**.** This is especially true for accused elderly persons without children or grandchildren as "maids." These "maids" serve as symbols of family bond. They indeed

serve as conduits – attracting visitations from family members who would otherwise not have visited the accused (see Musah, 2020) witch/wizard.

One day, while conversing with the Tindana at Gnani, he told a story to demonstrate how families abandoned their elderly accused members after their incorporation. According to the Tindana, one accused elderly woman had been living in the "camp" for over three years. During this period, no family members (including her biological children) paid a visit. Because there was inadequate accommodation, the woman lived with the Tindana and was even fed by him. Her life and survival in the camp were solely dependent on the goodwill of the Tindana. During an interview with this elderly accused woman, she noted that even though she was still supported by the Tindana, the support witnessed a major downturn when she moved to a thatch room which was given to her by the Tindana after another accused witch had relocated. One day, the Tindana informed the woman's family members that she was dead. To the amazement of the Tindana, her family members, far and near, quickly mobilised a vehicle and motorcycles and made their way to the "camp" to claim the body for burial. However, they were shocked when they arrived only to realise that the old woman was not dead, but well and healthy. According to Tindana, he adopted this strategy to measure the reactions of the accused's family.

Although living conditions were difficult for the elderly women in the "camps," the pattern of social life reflected everyday realities in ordinary communities. On a normal day, the elderly women woke up early to start the day's activities. The chores included cleaning the compound, washing bowls, cooking, and fetching water. Although an accused woman could live alone, this was not common. Mostly, they lived in 2s or 3s. There was

no written timetable for daily cleaning of the house. Whoever woke up early could do the cleaning. The women start preparing their breakfast after cleaning and filling their pots with water. Sometimes they simply warmed the leftover food from the previous night.

While the elderly women occupied themselves with off-farm activities (such as petty trading or working for other people in the market) during the dry season, they provided labour to the Tindana and other villagers on their fields during the rainy season. They supplemented the support they received from NGOs, Churches and other philanthropists with token food or cash paid to them after working in their fields. Those who were lucky not to have been abandoned by their families also received additional support in the form of food and cash from home. Since the women lived on the principles of Goran Hyden's (2006) economy of affection, they did daily rounds of greetings. They visited their neighbours to check on their health and to greet them. In Gambaga, the elderly women mentioned that by visiting friends and neighbours to greet, they could get to know who was sick and hence needed attention or support from the rest. Going round to greet others was not compulsory and no sanctions were imposed if this was not done. The accused women explained their daily rounds of greetings in terms of respect for one another. For example, Napaga noted that to greet a neighbour was considered as *songsim* (help*).* She noted that greetings strengthened social ties and helped to forge economic cooperation since one could not borrow from a neighbour if one failed to frequently greet them.

Death and dying: The "forgotten dead"

Death and dying; a state and a process, are intricately connected with emotions. Malinowski, Radcliffe-Brown, and Durkheim (Robben, 2018) formulated this idea. For Malinowski, death dredges up some ambivalent feeling and attitude especially in relation to "post-mortem bond between the bereaved and the deceased" (Robben, 2018, p. xvi). Several decades ago, among the Trobriand Islanders, Malinowski observed that a contradictory attitude was shown toward the dead: on the one hand to preserve the body, to keep its form intact, or to retain parts of it; on the other hand the desire to be done with it, to put it out of the way, to annihilate it completely … there is a desire to maintain the tie and the parallel tendency to break the bond (Malinowski, 1954, pp. 49–50). This kind of ambivalence was explained by Malinowski because of the combination of a fear of death and the desire for the "reintegration of the group's shaken solidarity" (Malinowski, 1954; cited in Robben, 2018). This ambivalent attitude long observed among the Trobriand Islanders still exists today in many societies including Ghana.

In his ethnography on Ghana, van der Geest (2000) turns the discourse of ambivalence on the ontology of death toward the direction of funerals. He argues that the "living" offers a better perspective to our understanding of funerals rather than the "deceased." Van der Geest (2000) then invites us to "think less of religion and more of politics, particularly, the politics of reputation" when discussing funerals or funerary rituals in Ghana.

In the so-called "witches' camps," the last painful transition accused elderly women passed through was their struggles with various types of illness due to their advanced age. The eventual consequence of these struggles was death. Some of the accused

elderly witches lamented that after toiling for several years to fend for their children, they were seen to deserve no "good" place to die but a "witch camp." These lamentations were sometimes accompanied with regretful rhetorical questions to the researchers and curses to biological children who initiated the accusations and abandoned them after their admission into the camps.

One hot afternoon, during a long interview with Sanatu (a 75-year-old accused woman) in her compound (in Kpatinga), she was full of bitterness about the way she (thought) had been abandoned by her two biological sons to die with indignity. She remarked,

> *I gave birth to five children, all males. Three died and the remaining two thought that I killed them with my witchcraft. Their father accused me first and they fully supported the accusation. They didn't want to openly attack me, so they instigated other community members to push for my banishment. My son [referring to the interviewer], who will give birth and turn around to kill the child? I feel pain talking about the conduct of my children. They have abandoned the very person who brought them to this world. They want me to die, so that they can come and pick the dead body. If only they will ever appear here. I live them to God. They will face the consequences of their actions on this earth before they die.*

Recollection of painful memories and outpouring of curses on accusers (mostly family members) characterised many of the conversations we had with elderly accused witches. Due to old age (and other factors), many of the accused had health problems. The women suffered from different ailments ranging from frequent headaches and waist pains to severe asthma and potential diabetes. They were also found to be exposed to water-related diseases. Some of the accused did not have health

insurance, while others lacked money to renew their health insurance premiums or cards. However, accused witches in the Gambaga "camp" claimed that the local Presbyterian Church sometimes helped them to renew their insurance premiums. Musah (2020, p. 304) graphically captures the position of health insurance in the camps in the following words:

> *…Although old residents 70 years and above, as per the health insurance law, and largely classified as indigent, are exempted from paying premiums, and thus qualify to enjoy free medical care under the NHIS, officers responsible for undertaking this responsibility hardly and rarely visit the camps. This category of residents also considers trekking to and from registration centres, located at the capitals of MMDAs, exhausting. In many instances too, transport costs to and from these registration centres are considered too expensive and beyond residents' reach. Hence, the goals of the NHIS remain to be seen, in practice, compelling and reinforcing residents' reliance on traditional or herbal medications.*

At Kpatinga, locals confirmed the vulnerability of the accused women when it comes to health issues. At one time, while speaking with a local teacher, he remarked:

> *You can see that these women are poor, they can't do anything for themselves. A small illness turns into a big one because there is no good care. They struggle to feed. None of them can afford decent medical treatment. The Tindana cannot sponsor their treatment. So, some of them die from simple illnesses that should not have killed them.*

During fieldwork in Nabuli, Damu was one of the lovely people we met. She was very old, probably in her mid-70s, but sounded jovial in her conversations. Sadly, Damu fell ill not long after we arrived in the village. When her condition worsened, Damu's

friends in the "camp" contributed some cash and bought some medicine from a licensed chemical store, but Damu refused to take it. Damu's friends hinted that she had no faith in biomedicine. She agreed to consult a herbalist but refused biomedical treatment in a hospital. Damu preferred to die at home, not in a foreign land. She asked her friends to inform her family back home about her condition. The village chief sent a message to Damu's kinsmen to come for her and initiate herbal treatment. The family delayed, and Damu passed on before they arrived. They carried the body home and buried it according to local traditions. Damu had died a painful death but, to an extent, her dream was fulfilled as she was buried in a manner prescribed by herself before her death.

Accused witches whose kinsmen refused or delayed in coming for the bodies were interred in the host communities. The burial and funeral rituals of dead accused witches were often done according to the religious beliefs she professed before her death. Reverend Duru, one of the longest serving officials with the local Presbyterian Church in Gambaga who had intimate working (social) relationship with the accused women explained how death was managed in the "witches' camp":

> *The Presbyterian Church buries those accused witches who die and are Christians, especially if family members are reluctant or delay in coming for the body. After the burial, we will hold a church service for the deceased. If the person is a Muslim, the Muslim community will also handle the burial process in line with Islamic requirements. Usually, after burial, the family members come to take the funeral home to perform. When Magazia Hawa died here, we buried her the Christian way and held prayers for her. But later the family also came and took the funeral home and performed.*

The stain of witchcraft was a very dirty one. Accused persons who became ill and died in the "witch camps" might receive proper burial from kinsmen, but the master status – "witch" – was never removed from the minds of kinsmen and other community members. At best, they could be described as the "forgotten dead" since they were not remembered by the living with any good account. They were not memorialised or immortalised and could never be listed as "ancestors" worthy of veneration. Their progeny carried perpetual shame and damnation of integrity.

Conclusions

In many cultures across Africa, old age is valued and respected. The elderly is believed to have acquired more valuable knowledge and wisdom by the mere fact of living longer than the younger ones. They, therefore, constitute a "learning institution" for the growing youth. Customs therefore demand the youth to respect and revere the older ones. Unfortunately, this is not the case in some African societies including Ghana. In northern Ghana, sheer disregard for elderly people and the constant derision of old age is manifested in the existence of the so-called "witches' camps" which are inhabited by the elderly, especially elderly women. As this article has amply demonstrated, the existence of the camps enacts three phases of painful transition that accused elderly people go through. Even though most elderly people have higher expectations of aging in dignity, social support, veneration, and happiness, for those who unfortunately transit through the three stages identified by this article, old age is considered a painful and a regretful transition.

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Fiscal Planning and Hobby Engagement as Significant Contributors to Psychological Wellbeing in Post-Retirement

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Mental health has steadily gained currency in Ghana; however, people still prioritize physical health over mental health although the two go hand in hand. Having sound psychological well-being is key to enjoying one's retirement. Psychological well-being simply refers to the quality of life of an individual. It is made up of a cocktail of elements such as being in ideal physical health, feeling good about oneself and the ability to function optimally. Simply put, a combination of optimal life satisfaction and the ability to function sufficiently is imperative. Being properly prepared for retirement has a considerable influence on one's psychological well-being (Amorim & França, 2019). In Ghana, very few people have the comfort of planning for retirement. As a result of the topsy-turvy nature of our economic climate, many Ghanaians live from hand to mouth. Savings are considered a luxury while developing or engaging in healthy hobbies is dangerously akin to an unfathomable pastime tethered onto the erroneous perception that only the wealthy have the benefit of engaging in healthy hobbies.

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Usually, when the issue of struggles after retirement is mentioned, many believe that it is an issue that plagues only those in the informal sector since they may not be exposed to the requisite resources to plan their lives. This, however, is a fallacy since research has shown that very few people (irrespective of

socioeconomic status) plan for retirement (Lusardi & Mitchell, 2011). This is heartbreaking because the ideas many people have conceived about retirement turn out to be a utopic fantasy whose real-world equivalent is unpleasant. This painful reality many unfortunately find themselves in often stems from improper planning for life after work. Ideally, retirement planning should begin long before one reaches late adulthood. Research shows that young adults do not see themselves as growing old and have a false sense of invincibility and this is seen in how many young people described COVID-19 as old people's sickness (Ayalon, 2020; Zhou et al., 2020). Planning for old age should be a lifelong process and should not be delayed till the year of retirement. Fiscal planning and engaging in hobbies have the potential to improve psychological well-being after retirement.

In this discourse, fiscal planning is tentatively defined as financial planning in terms of segregating funds for future expenditure, unexpected financial commitments, saving for health bills and, investment when one no longer has access to monthly paid income after retirement. Hobby engagement is described in terms of healthy pastime activities. A hobby is a regular activity that is done for pleasure, usually in one's spare time (Parker, 1996). Engaging in creative and artistic endeavours, playing sports, and engaging in other amusements, gardening are all examples of hobbies.

As the adage states, *money answereth all things*. As religious people, one would assume many Ghanaians would take a cue from that and invest in the future. Granted, a multitude of factors can stall fiscal planning, however, critically analyzing the frustrations of being financially insecure after retirement gives the impression that there is no excuse not to plan economically to combat the vicissitudes of life after retirement. Several retirees find themselves paying fees even after pension, others

find themselves having to fend for their adult children because of the high unemployment rates. This nullifies the idea of filial responsibility to an extent because culturally, it is expected of children to take care of their parents when they reach adulthood, but this is increasingly becoming a challenge. To add, people who use humour as a coping mechanism are potentially less likely to take fiscal planning for ageing and retirement seriously. There are often statements of how money meant for a riotous living cannot buy plots of land or take care of hospital bills, followed by the suggestion that one must 'enjoy life' whilst one can. Further, people are considered stingy when they opt to save for the future. These among many reasons fuel the negative attitudes toward financial planning among Ghanaians.

Why is fiscal planning necessary?

There is consensus and scientific evidence to show that life expectancy is increasing steadily (Crimmins, 2021). Most working-class people retire at 60 which points to the fact that they have 15 or 20 plus years with no working income. Looking at the unimpressive pension scheme we have, it is dangerous, irresponsible to bank all one's hopes on one's pension for survival. To survive functionally post-retirement, one should have avenues for income that is almost equivalent to what one was earning pre-retirement. This is because expenditure keeps going up and logic suggests earning significantly less would be a problematic venture. During retirement, most people expect to live off their pensions and there have been reports of the unsustainability of pensions to maintain a healthy lifestyle (Jones, 2021). This inadvertently leads to stress and being overly cautious of spending which may lead one to be very irritable, especially if the individual is still the breadwinner, thereby negatively impacting psychological wellbeing. Financial

instability is a dreadful hole to fall into and the pits of hell may even be conducive if a retiree is plagued with insalubrious health challenges that come with ageing.

Investing with a conscience

Monetary investments may be one way of escaping the post-retirement tragedy. Investing allows individuals to have extra sources of income without having to actively work, and it can also serve as a buffer for unexpected financial challenges. It cannot be established enough that PENSIONS ALONE CANT SAVE YOU (unless the individual is among few outliers who earned way beyond the average pay of the average Ghanaian). Generally, relying on your pension may be suicidal. Whilst one is engaged in meaningful work, it is advisable to invest in landed properties or other investment portfolios as made available by credible banks. This will go a long way to supplement the pensions provided by the government.

Investments are not monetary alone, and this is where one's conscience comes in. According to the American Psychological Association, "the brain's volume peaks in the early 20s and gradually declines for the rest of life" (APA, 2006). Scientists are of the view that memory declines begin as early as 45 years. The brain begins to lose its acuity and its reasoning ability depreciates with time. Research shows that over 10 years, there is a 3.6% decline in mental reasoning in both men and women aged 45-49, while the decline for men aged 65-70 was 9.6% and 7.4% for women (Boyles, 2012).

However, the decline can be slowed down by lifestyle habits. It is not required for ageing, or for life after retirement, to be marked by severe decline. As one gets older, one's mental capacity can be maintained. Simple modifications in our habits can help

us maintain our mental sharpness for as long as feasible. The activities an individual chooses to or not to engage in have a significant impact on memory abilities.

Pursuing both behavioural and intellectual challenges, no matter how daunting, is part of the proven ways to slow down the natural memory deterioration process. New difficulties force the mind to extend and generate new neural pathways. Taking up hobbies could be the finest option.

Beneficial hobbies

Brain stimulating games

The brain can keep adapting and making new neural connections. At one age, it is advisable to learn new things such as checkers, chess and other board games which require a lot of brainpowers and help improve cognition. Chess, for example, has been shown to improve memory, enhance reading skills, help in planning and foresight, and enhance problem-solving skills (Erika, 2020).

Gardening

Taking up gardening is a very useful hobby to adopt for a healthy lifestyle. Research has shown that gardening is the best way to spend time in nature. It is a space where you can clear your mind, enjoy multiple activities, and cope with your different emotional states—stress, anxiety, depression, etc. Gardening always contributes to positive mental stimulation.

Engaging in social activities

Finally, engaging in social activities is a form of investment which is essential for the ageing population. Social activity has been

identified as one of the most consistent predictors of peoples' subjective reports of happiness (Cooper et al., 1992). Engaging in social activity serves as a buffer against loneliness. Loneliness is one of the major psychological problems that the elderly face. As one gets older, there is attrition in the social circle. Engaging in social activities helps the elderly to derive emotional sustenance from others aside from the family. To live a long and prosperous life, a sense of emotional nourishment and well-being are very crucial. A combination of these two factors can go a long way to repel certain physical ailments and ameliorate the expansion of the mental faculties. Elderly people who partake in social events regularly and form bonds with their cohorts often believe they feel loved, needed, and present. Loneliness is a killer. Social activities can be a viable antidote to loneliness.

Furthermore, experts have observed that meaningful friendships, enjoyable activities for older persons, and normal intellectual activities can all help to slow down and even delay the onset of some disorders. Higher levels of social activity and the quality of social groups have been demonstrated to lower the risk of cognitive impairment as people age.

Conclusion

Pursuing psychological well-being is crucial to healthy ageing. There are many avenues available to achieve this and chief of these avenues are fiscal planning to act as an economic buffer and developing hobbies to act as memory trainers and a social cushion.

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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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Strengthening Distance Education Delivery to Adult Learners in Higher Education Institutions in Ghana

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Abstract

Distance education is witnessing increasing participation in Ghana, fuelled by the deployment of information communication technology (ICT) in higher education institutions (HEIs). Many universities, hitherto single delivery mode, are now delivered through ICT teaching and learning tools as adapting blended approaches to distance students. Despite the potentials of ICT teaching and learning making adult learners self-directed, they are fraught with challenges. This review theorizes distance education delivery. First, a summary of the wider context of distance learning was made. Second, assemblage theory was explored in relation to distance education (or ICT enhanced) delivery. Third, the Ghanaian case study was explored in context. Last, there is a critical gaze on how governments in developing countries partner higher education institutions by providing laptops, and resolving other challenges related to distance learning delivery to adult learners. This initiative supports the digitisation process, self-directed, and lifelong learning that drives economies.

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Introduction

Distance education is witnessing increasing participation of non-traditional learners in higher education institutions (HEIs) (Allen & Seaman, 2017). From the outset, distance education was differentiated from traditional education by serving non-traditional learners (Saba, 2016). As global and local recognition of lifelong learning has increased, so have the available learning outlets (Davidson & Goldberg, 2009; Ingram, et al., 2009; Leinonen, 2009, cited in Head et al., 2015). Contemporary modes of delivery in distance education rely on the use of technology (Heredia, Carvalho & Vieira, 2019), and adaptation of teaching and learning to new technological conditions has been revolutionary (Gunter, Raghuram, Breines & Prinsloo, 2020). Adult learning has become essential in the digital age, yet it seems to be one of the best kept secrets (King, 2017). Since the mid-1990s, digital transformation has changed the face of distance education (Zawacki-Richter & Qayyum, 2019). In the last 20 years, distance education has moved from the fringes into the centre of mainstream education provision (Xiao, 2018).

This study aims at strengthening distance education delivery in Ghana. The purpose is to *empower* adult learners to become self-directed learners. The reason is that adult learners in Ghana are unemployed, and poor, to cushion themselves through the distance education mode of learning. Meanwhile, learning by distance education mode requires financial independence of individuals involved, institutional and government support (Author, 2020). The University of Ghana started rolling out distance education with the print-based modules since 2007. It went blended in 2013 using the SAKAI Learning Management System (LMS) teaching and learning tools. This approach of learning provides more *flexible* learning opportunities to learners (Carlsen, et al., 2016). It improves upon the issues of access and

participation in HEIs (Daniels, 2010), and makes learners become self-directed in their learning endeavours (The Economist Intelligence Unit, 2008). However, the cost of adult learning seems high, if one considers fees paid by adult learners enrolled on distance education programmes run by public and private universities in Ghana. Adult learners reading Bachelor of Arts (Humanities) and Bachelor of Science (Administration) for the 2018/2019 academic year paid fees ranging from Gh¢3,017.00 and Gh¢3,209.00, respectively. The Dollar equivalents of fees stated in Cedis are $650.92 and $692.34, respectively. It becomes difficult for adult learners pursuing degree programmes by distance education mode to pay the fees. That demonstrates poverty facing adults' learners in financing education in Ghana. Adult learners would have combined jobs with learning, but they do not find jobs to do to fund their education.

It has been eight years since University of Ghana went blended with the SAKAI (LMS) teaching and learning tools in delivering distance education mode. It is expedient to ascertain how distance education delivery has been conducted to enable adult learners' access to higher education. There appear challenges facing users of the SAKAI (LMS) tools to learn. The issues of poor Internet connectivity, poor interface of the SAKAI (LMS) teaching and learning platform, lack of computers and accessories, and lack of retooling and refurbishment of the computer laboratories have been identified as some of the challenges facing learning by distance education mode (Biney, 2020; Carlsen et al., 2016). Considering the challenges over 80 percent of University of Ghana adult learners go through in accessing computers at Accra Learning Centre to learn, make the researcher argues that the Government of Ghana will benefit economically by providing distance learners with laptops to learn. The Government of Ghana and 'Chinese Phase Two Project' that led to up-scaling of computer and Internet facilities in the University of Ghana,

and 8 Learning Centres, gave birth to the SAKAI (LMS). This project which provided one iPad at a subsidized price to an adult learner on distance education programme was implemented for three years, but never continued. However, today's students are social-media-savvy learners (Parkay, 2013), and do their learning online. This makes it imperative that the Government of Ghana comes to the aid of providing adult learners with laptops to learn. The point is that the cost of refurbishing and retooling computer laboratories for every 5 years may be too huge for University of Ghana to bear; making provision of laptops each to every student cost effective, comparatively. Envisaging increasing student population in the 2020/2021 academic year from the free public Senior High School (SHS) into the Universities, requires the expansion of infrastructures, including building new state-of-the art computer laboratories to cater for the students. The cost may be huge to bear with the latter.

Strengthening distance education, in this context, is about providing affordable and accessible lifelong learning opportunities and support to adult learners through varied instructional modes to prepare them for employment or career advancements. The learning activity can be done anytime, anyplace, and at the convenience of the adult learner; yet support is provided to adult learners in times of need. Such learning opportunities are provided through an array of distance learning technologies, and delivery systems, including the SAKAI (LMS) teaching and learning tools, and personal laptops. This theoretical paper seeks to fill this gap by first summarising the wider context of distance learning. It explores the assemblage theory in relation to distance education. It zeros in on the Ghanaian case study. The paper discusses data presented in the case study in the lens of assemblage theory. It finally concludes by reflecting on assemblage theory, the case study and linked up to the wider literature in strengthening distance education delivery in Ghana.

Summary of the wider context of distance learning

Distance learning, a mode of delivery of education to meet various learning needs decades ago, was known as correspondence education (Aggor, 2004). Distance education has a long history, however, the adaptation of teaching and learning to new technological and social conditions has been revolutionary (Gunter, Raghuram, Breines & Prinsloo, 2020). Thus, the future of distance learning seems bright considering the increasing demand for education. Historically, what was once the pathway of an elite with few higher educational laurels has now developed into the foreseeable pathway for many (Santiago et al., 2008; Gidley et al., 2011); because the central reality of the 21st century involves the massification of higher education (Altbach, Reisberg & Rumbley, 2010); making educators aware that online distance education is the way of tomorrow (Zawacki-Richter & Anderson, 2014; OECD, 2016). This enabling programme can today prepare rural [adult] learners for success at higher education (Shah et al. 2012; Crawford & Erve, 2015).

Flores (2017) argues that distance education has increased significantly across the United States (U.S.). The proportion of the higher education students taking advantage of distance education courses in the U.S. has increased each of the last three years- at 25.9% in 2012, at 27.1% in 2013, and at 28.3% in 2014 (Allen & Seaman, 2017). Today, we have *mega universities*, including Indira Gandhi National Open University with over 4,000,000 students, Bangladeshi National University has over 2,079,182 students, Anadolu University has over 1,974,343, and University of South Africa (UNISA) also has over 355,240 students (Everipedia, 2018). The Government of Canada also invested CAD$20 million to expand distance education across the Caribbean. The project sought to *strengthen* the Open Campus of the University of the West Indies (UWI) to make high-quality education available

to more people across the Caribbean using distance education technologies. This led to over 20 new degree programmes, over 130 new courses online, and 37 new continuing and professional education programmes developed (SDEC Project, 2018).

In the Sub-Saharan Africa, perceived as low-and-middle income countries (LMICs), Nigeria, has made progress with distance learning through the National Open University of Nigeria (NOUN), with over 300,000 students (Everipedia, 2018). Adult learners work, earn and learn by distance learning mode, and have a wide range of courses to choose from. However, a focus on enrollment growth at mega-universities has led some academics to question their value (Venable, 2019). Yet, blended learning could be the new century's educational game changer because it promises a best-of-both-worlds solution to higher education's acute problems of student retention, success, and engagement (Snart, 2010). Residential tertiary education is expensive, but distance education can benefit from economies of scale (Daniels, 2010). However, absence of adequate faculty care and institutional support can aggravate the very problems blended learning is meant to address.

Ghana's current population is 31.37 million (United Nations Data, 2020). Today's young adults require dynamic education, and as social-media-savvy learners (Parkay, 2013), want to construct their own reality and assume leadership roles in their spaces. Anamuah-Mensah (2015) indicates that the University of Education, Winneba (UEW) attracted over 45,000 students to its distance education programme. The University of Cape Coast (UCC) garnered 42,000 students' population, and Kwame Nkrumah University of Science and Technology (KNUST) has distance education students of 10,000. The University of Ghana has 10,000 adult learners on its distance education programme, reading degree programmes by blended distance education mode-

thus face-to-face and online learning through the SAKAI (LMS). The challenges in distance education mode of learning emanates mainly from the HEIs, adult learners, and the Government of Ghana. The institutional policies comprising entry requirements, lack of infrastructural facilities and learning equipment are some of the challenges involved in the delivery of distance education in Ghana. On the side of adult learners, the difficulty in combining work with learning, poor time management, lack of savings culture to fund the cost of the programme, as well as inadequate support from the extended family (Biney, 2017) were challenges identified. On the Government of Ghana, lack of financial and technological support to adult learners pursuing degree programmes by distance education mode at HEIs is the bane.

The policy on the payment of fees seems not favourable to some adult learners. The policy is that fees must be paid in two instalments, thus, sixty percent in the first semester, and forty percent in the second semester. Some poor homes and families cannot afford to pay the fees, compelling some successful applicants to defer their programmes. To access government financial support, one must first accept the admission offer, and pay his or her fees for the first semester before applying for financial support. Some adult learners who are 50 years and above are not qualified to apply for the students' loan. This is not the case of some jurisdictions, including Sweden, according to Wickberg (1991), where at the age of 70, the Government finds it worthwhile to fund adult learners' education, and pay them stipends to upgrade themselves and work for betterment of the country. Some young adult learners in Ghana who are unemployed, and their families not financially solvent, do have difficulties supporting their wards at higher education to learn by distance education mode.

Faced with unemployment, many of the young adults in Ghana lack the ability to save towards their education. The culture of savings is not part of the young adults who prefer to buy the smartest phone in town with their limited funds but would not cultivate the habit of savings toward their education. This is not surprising because, according to Parkay (2013), today's young adults are entertainment driven. Many other adult learners, especially those who are working, have problems with planning and management of time (Biney, 2017). Although the adult learners have enrolled to pursue degree programmes at HEIs, they tend to place too much attention to their work and more to that of learning. The work they do brings them money to keep the family going, and pay their fees, but attention to planning to be available to learn is equally important. They found education as important part of their work, so equal attention should be placed on their studies, to excel in the courses they have opted to read. Those who work hard and get enrolled into the university become frustrated to the extent that the HEIs running distance education programmes lack the requisite infrastructural facilities, including lecture halls, computer laboratories, chairs and tables and reliable high speed Internet facilities to make their studies comfortable. In this digital era, lack of campus-wide WiFi points, and accessibility to Internet facility, would frustrate adult learners in their lifelong learning drive. Today's *iGeneration* learns at a go, very social, and love to share with others (Parkay, 2013). Therefore, lack of reliable Internet facility at the Learning Centres would limit their chances of succeeding in distance education programmes.

Today's adult learners are skilled multi-taskers, and always engaged in parallel process. Eurich (1990) opines that new learning technologies not only teach skills but advance our understanding of the learning process. This supports Larsson (Cited in Carlsen et al., 2016) assertion that creative learning

draws upon expressions and demonstrations between learners in cooperation to challenge their ideas and beliefs. Active interaction and dialogue among learners and lecturers are keys to success in learning at a distance. Bates (2016) notes that distance education is a *social process,* which requires communication among learners, teachers [tutors] and others. Thus, active interaction, conversation, and practice rather than theory, is one sure way that adult learners using SAKAI (LMS) platform should engage in learning to become digitally proficient. King (2017) notes that technology innovations require people to continue their learning across the lifespan, and independently use critical thinking, and problem-solving skills. Ghana stands to gain from distance learning because it is not going to lose the trained human resource even as they upgrade themselves. Improved performance and production at the workplace would not be disturbed. Governments can use the scarce financial resources at their disposal to support other components of the education sector, and other sectors of the economies to engender development. This confirms Aggor's (2004) observation that the future of education in [developing countries] points to distance education, and efforts and resources need to be directed at distance education. He adds that the universities running distance education should see it as an opportunity to effect curriculum change, and introduce demand-driven courses, for which adult learners are willing to pay. King (2017) avers that adult learning, [of which distance education is part], possesses the potential of helping people understand vast number of connections we make daily in our lives in this digital age. As people learn, they establish connections, foster networks, and improve the quality of life which invariably impacts the development of countries.

Assemblage theory

This paper draws on assemblage theory espoused by Manuel DeLanda, a philosopher and formidable thinker of high calibre. I related assemblage theory to shaping the trajectory of distance education delivery in decades; thus, from correspondence education, face-to-face (use of modules), blended learning to digital, online, or virtual learning. Every new trajectory of distance learning delivery is an improvement of a kind on what existed before, all in a bid of producing smart and innovative adult learners. However, various trajectories as they exist in distance learning are interrelated and intertwined. Assemblage theory is a refined presentation of an already long intellectual trajectory (Harman, cited in DeLanda, 2016). What then is an assemblage? According to DeLanda (2016), assemblage

> "Is a multiplicity which is made up of many heterogeneous terms and which establishes liaisons, relations between them, across ages, sexes, and reigns – different natures. Thus, the assemblage's only unity is that of a co-functioning: it is a symbiosis, a 'sympathy.' It is never filiations which are important, but alliances, alloys; these are not successions, lines of descent, but contagions, epidemics, the wind" (p. 1).

DeLanda (2016) uses the original term *agencement* to refer to the action of matching or fitting together a set of components; an ensemble of various parts that mesh or fuse together into a homogeneous whole. That is, the delivery of distance learning by correspondence has transformed into what we call today online, virtual, or digital learning. It is on this basis that Hargis (2020) avers that online teaching [and learning] is not new. DeLanda talks about virtual, a term for something that is real but not actual. Key elements in assemblage theory including virtual, relations,

multiplicities, co-functioning were drawn on in the study. Indeed, an assemblage's diagram captures this virtuality– the structure of the possibility space associated with assemblage's disposition. Emanating from the definitions emphasised two main areas- the part that are fitted together are not uniform either in nature or in origin, and that the assemblage actively links these parts together by establishing relations between them.

Learning by distance education mode is interactive, dialogical, employing intrinsic and extrinsic motivation and autonomy; thus, empowering adult learners to become creative thinkers and innovators (Wedemeyer, 1981 cited in Saba, 2016). Distance education has changed over the last 50 years; hence Zawacki-Richter and Anderson (2014) assert that technology has opened opportunities to implement programmes with high relevance for quality distance education (Carlsen et al., 2016). New interactive technologies are being produced to drive learning. Capra (2014) asserts that online learning has become a permanent feature on college campuses. Single mode campus-based institutions which advocated transmission model of teaching and learning have adopted the dual mode approach, deployed ICT teaching and learning tools to aid learning at a distance. Indeed, *virtuality* in learning is key today, hence, universities in LMICs running distance learning programmes should provide adult learners one laptop each to engage in online learning because that is where learning has taken us today. It means that the digitisation process embarked upon by the Government of Ghana is accelerated to aid online learning since this is one step of making adult learners become self-directed in this digital era. The assemblage theory also talked about multiplicities or relations of different natures, meaning successful delivery in distance learning programme, and adult learners' success in learning hinges on financial preparedness or independence of learners to fund their education, Faculty members in HEIs readiness to guide adult learners in

their studies, and appropriate government policies to cushion adult learners in lifelong learning drive are important. When key stakeholders in adult learning play their roles effectively, there is that likelihood that Ghana would be on the path of producing digitally literate workers to impact productivity at workplaces.

Holmberg (1993) argues that teaching and learning in distance education is a conversation-like interaction between students and tutor of the supporting organisation administering the study. No wonder, Interactive Telecommunication Systems (ITS) and Computer Supported Collaborative Learning (CSCI) emerged with student interaction at the forefront became the beating heart of learner-centred strategies and environment (Carlson et al., 2016). Moore (1989) discussed three types of interaction-learner-content, learner-instructor, and learner-learner. Moore (1993) developed a theory on transactional distance, meaning the more dialogue and interaction taking place in a distance education course, the less distance the learner experience. Thus, much could be realised in distance education when parties involved in the learning endeavour are active on the learning platform; otherwise, this opportunity would not be realised. This is the relations and co-functioning roles in distance learning assemblage theory emphasized.

Distance education is the fastest-growing mode of formal and informal teaching, training, and learning, and is multi-faceted in nature, encompassing e-learning and mobile learning, and immersive learning environments (Zawacki-Richter & Anderson, 2014). The emergence of modern technologies has changed the nature of educational processes (UNESCO, 2015). Research confirms the favourable relationship between the use of technology and quality of an interaction (Bannan-Ritland & Dabbagh, 2005). First, lightweight, and portable devices- ranging from mobile phones, tablets, PCs to palmtops- have liberated

learning from fixed and predetermined locations, changing the nature of knowledge in modern societies (UNESCO, 2015; Kilfoil, 2015). Mobile and smart phones, tablet computers, e-readers, hand-held consoles are making learning become more informal, personal, and ubiquitous. We talk about *mobile learning* in many learning settings (UNESCO, 2015); however, teaching and learning processes in early distance education solutions were managed with books and letters. Through printed means, students gained access to the subject matter, and letters supported interaction between tutors and students. It is time-consuming yet necessary *dialogue* for learning. Developments in technology have meant a push forward for distance learning, and distribution of learning materials have found innovative solutions in ICTs. Smartphones, the worldwide web, Internet, applications such as chat, blogs, wikis, podcasts, SMS, MMS, and other communication platforms are driving distance education digitally. These technologies have opened opportunities for presentations of subject matter, and easy access to learning materials, and implement high quality distance education (Carlsen, et al., 2016). The next section on Ghanaian case study is examined.

The Ghanaian case studies.

The University of Ghana Distance Education programmes commenced in 2007 in 8 Learning Centres in the then 10 regions, now 16. Distance education went blended learning in 2013, using face-to-face and SAKAI Learning Management System (LMS) platform. Blended learning (BL) is the use of a mix of distance learning technologies to engage students and bring about optimal learning outcomes (QAA, 2020; Maguire & Zhang, 2007). Accra Learning Centre is the biggest of 11 Regional Learning Centres of University of Ghana, hosting over 80% of all distance education students. The state-of-the art computer laboratories,

video-conferencing rooms, smart classrooms, discussion rooms and presentation practicing rooms help adult learners learn. PowerPoint slides and video-recordings of contents of courses taught by lecturers are uploaded on the SAKAI (LMS) platform. Students undertake interim assessment (IA) online on the SAKAI (LMS) platform, building up their digital literacy skills. Some adult learners attend tutorials less with books and pens, but more with learning tools, including laptops.

Notwithstanding opportunities of modern-day approach to learning instituted by universities running distance education in Ghana, the high cost of fees, as earlier on indicated, is deterring potential adult learners to learn at HEIs by distance education mode. This is against the backdrop that the young adults in Ghana are faced with unemployment. If young adults have work to do, and earn some income, they would be motivated to learn by distance education mode. The financial support young adults used to get from their parents, and the extended family relations to learn, seem not forthcoming. The Government of Ghana has produced job creation initiatives, including 'one district one factory,' planting for food and jobs' among others, yet many young adults in Ghana are still unemployed. Adult learners who have employed salaries seem not good enough to cushion them through the distance education mode of learning. Hence, some adult learners defer their programmes; others are forced financially to truncate their programmes. Many others, due to financial constraints, failed their papers and re-sit. Many more others take a long time to complete their programmes due to financial difficulties during their programmes. On the other hand, well paid adults desirous to learn, do take advantage of learning at HEIs by distance education mode due essentially to *flexibility* in learning. This ties in well with the Economist (2017) observation that:

> "*The lifelong learning that exists today mainly benefits high achievers- and is therefore more likely to exacerbate inequality than diminish it, adding that if 21st-century economies are not to create a massive underclass, policymakers urgently need to work out how to help all their citizens learn while they earn*" (p. 9).

Meanwhile, participating in distance education creates opportunity for adult learners to work, learn and earn at the same time (The Economist, 2017). Again, distance education is a major form of professional development for pre-service and in-service teachers in developing and developed countries (Burns, 2011), since no teacher leaves his family and job for extended periods to undergo any upgrading programme. This quality of distance learning drives home the idea of *virtuality* in learning stressed by Manuel DeLanda assemblage theory. Indeed, if teaching and learning can be experienced seamlessly anytime, anyplace, and at the convenience of adult learners pacing at their own rate, learning becomes comfortable. In such situations, productivity can be increased at the workplace because innovative ideas acquired are infused into work output.

Major contextual challenges and benefits

Ghana practices extended family system, and each is his or her siblings' keeper. Ghanaians believe in cooperation and togetherness. Globalisation, education, and cultural imbibing of alien western cultures make it difficult for family members to continue their education through receiving support from more affluent family members. Family and financial challenges constitute barriers to adult learners accessing HEIs through the distance education mode. On the contrary, higher education is now an option for adults who were unable to gain access after leaving school, or who have found they need a tertiary

education qualification because of labour market changes (Sellar & Storan, 2013). The Government of Ghana has a role to play in the provision of education of the adult population in Ghana (Biney, 2017), yet has not put in place solid systems to get a critical mass of adults educated. Adult learners who are 50 years and above do not qualify for financial support from the Students Loan Trust Fund (SLTF); an institution built out of the Social Security and National Insurance Trust (SSNIT), to provide financial supports to students' in HEIs. In contrast, Wickberg (Cited in Newsweek, 1991) asserts that in Sweden, you learn if you live. The government pays for full tuition. Learning should be perceived in lifelong context, for there is no better way to make good citizens than educating able-bodied men and women to work (Biney, 2017). Furthermore, jobs in Ghana are non-existent (Biney, 2017), and the reality is that some parents are not working themselves, making it difficult to fund their children in HEIs. Another challenge facing some young adult learners is that they cannot afford personal laptops to learn, and not cushioned by government, to motivate them to learn in distance education mode.

On benefits of distance education, Bates (2016) asserts that it has proved to be robust and relevant mode of educational delivery. The Economist (2017) and Daniels (2010) assert that one important 21st -century skill to possess at workplace is to be a self-directed learner. Today's distance education delivery ensures that constraints in terms of access, time, and place as well as pace and methods of study are minimised due to improved technologies used. More so, distance education delivery improves not only the potentials of teachers, but many professions to develop better links between new work practices, expertise and the application of modern technologies and methods of ensuring productivity at workplaces. Effective distance education delivery engenders reduction in the cost of education (Keegan, 2004) and (Saba,

2016), and this conflicts with the case of Ghana. However, distance education delivery affords increased interaction between lecturers and students and guarantees the use of new and improved technology. It guarantees self-pacing in learning and ensures the constraints on learning in terms of access, time, place, pace, and method of study are minimised (Keegan, 2004).

Discussion

The emergence of e-learning solutions has brought in its wake the possibility of technology in bridging the gap between students and students; students and instructors via virtual communication and resource sharing (Bervell & Umar, 2020; Saba, 2016). This observation ties in well with Manuel DeLanda multiplicities of assemblage, and Gunter et al. (2020) assertion that the university is better seen as a space of multiplicity through which knowledge circulates. Thus, when HEIs and faculty members- lecturers and tutors employ the state-of-the art ICT teaching and learning tools, including the SAKAI (LMS) with high-speed internet facilities in their facilitation, adult learners could bridge the 'distance' in their studies, and engender self-directed learning, and become lifelong learners. It also means that group learning and discussions could improve among adult learners to impact positively on their studies.

Despite positives observed from BL at University of Ghana distance education, critical questions remain: Are adult learners really using the SAKAI (LMS) digitally relevant tools to learn? If they do, is it impacting on their performance in the courses they are reading? I posed these two questions because at University of Ghana, for the past three successive years- 793 in 2015; 905 in 2016; and 810 in 2017 adult learners on distance education programmes have been failing and re-sitting their courses. If the SAKAI (LMS) teaching and learning tools are meant to aid

adult learners improve upon their learning endeavours, then this should not be re-sit numbers we should be observing. This confirms what Woodley and Simpson (2013) call 'an elephant in the room of distance education' – its dropout rate, and I am referring to re-sit of adult learners.

Even as the researcher situates this review in Ghanaian context based on the experience garnered, the effects of what other countries doing similar things, within the same context are highlighted here because we are living in a global world and needs to learn from one another to improve our situation. Further, the Open University, and other universities in the United Kingdom (UK), have long track records on the deployment of distance education. A study conducted in the UK by Inkelaar et al. (as cited in Simpson, 2015) indicates that distance institutions tend to have much lower graduation rates than the UK full time average- the so-called 'distance education deficit'. He cited the London University International Programme as an example of this deficit as its degrees are presented in two different modes, one reinforced by face-to-face support at local institutions, the other entirely at a distance. The course content and examinations are identical in both modes, but the supported option is better by around 61% to 16%. Simpson (2015) said the main reason for this deficit is due to the distance students' isolation from their institutions, their teachers, and other students- what Moore (1990, 2013) calls the 'Transactional Distance' between all parts of students learning environment. Adult learners have disadvantages studying part-time and juggling family and job demands. To forestall this problem, Simpson (2015) calls for strengthening of students support services as one key step of addressing dropout, and failure rate, among distance education students.

However, the methods used in distance education, and the focus on the students as learners, the flexibility it offers in learning, and on global reach, keep stimulating interest across the field of education using ICTs teaching and learning tools in learning settings. Hence, efforts must be made in strengthening participation and delivery of distance education, including building of capacity of staff running distance education programmes, provision of infrastructure such as lecture theatres, computer laboratories, and installation of learning softwares (.e., SAKAI, LMS) teaching and learning tools and high-speed internet facilities. These facilities are inadequate, considering the increasing number of adult learners enrolled in the distance education programmes.

The financial difficulties facing adult learners, notwithstanding, the number of potential adult learners wanting to continue their education by distance education mode keeps increasing as compared to the inadequacy of infrastructural facilities at the Learning Centres. This calls for refocusing of HEIs running distance education to put the programmes in a better stead. Adopting multimedia or virtual approach of teaching and learning, such that adult learners access learning materials at home, and on wheels, would help mitigate some of the constraints, including lack of lecture halls to accommodate adult learners at the Learning Centres. Mahlangu (2017) avers that adult learners have a duty to take greater responsibility for ensuring that their own skills or needs are met, meaning, adult learners begin to plan and manage their time, energy, and other resources for their studies. For distance education to make an impact in our part of the world, we should pay attention to *capacity building* of staff running the programmes. The capacity of staff involved in distance education is not regularly built. Staff of distance education programmes capacity is to be built regularly. Senior academics must develop a positive attitude towards distance

education and stop seeing it as a periphery activity. This means that dedicated staff are appointed for distance education to work with academic departments to deliver seamless programmes.

Thus, recruiting young academics to work with senior academics should be the priority of the University. It is, however, argued that bringing young academics on board as distance educators without financial motivation and support to increase capability, they would leave as senior academics would do. Instead, when senior academics are motivated, they can relearn on the job as younger academics would do and stay at the distance education departments. There are efforts in mentoring younger academics by senior academics at the Department of Distance Education, and more young academics are being recruited to strengthen delivery of distance education programmes to adult learners. More so, retention of staff on distance education programmes depends on *motivation*, because theories concerning motivation and adult education maintain that individuals are innately motivated to learn (Ahl, 2006). It is more likely that motivated staff would be more committed to their work, learn, and improve performance to impact services rendered. Again, the ICT teaching and learning tools to deliver distance education programmes are witnessing increasing advancement, and until staff capacities are regularly built; they cannot deliver the modern-day digitally based distance education to benefit adult learners. Thus motivation, commitment, and capacity building appear ways to retain critical staff to work for distance education programmes. Thus, a lifelong learning mindset is to be cultivated in staff in HEIs providing distance education to a broad range of adult learners. When this is done, the critical staff in distance education would continue to be committed to adult learners, because ICTs teaching and learning tools have a protean character; thus, they keep changing quickly and easily.

Although technology may be a disruptive innovation in ways not intended, it is one important tool in delivering distance learning programmes; hence HEIs providing distance education in LMICs start retooling and refurbishing the Learning Centres. This is against the backdrop that technology drives innovation in different spheres of life; yet innovative capacity of technology is very much conditioned by the level of digital skills of the population (Linden, cited in OECD, 2016). Therefore, HEIs must start equipping computer laboratories with new computers and accessories to make adult learners feel comfortable accessing learning materials and learning. As adult learners take their interim assessment online with installed computers, and Internet connectivity strengthened, they may feel at ease learning online.

The provision of learner support services is crucial in the facilitation of distance education programmes. Following the increasing number of adult learners at Learning Centres, the administrative staffs are to be proactive in providing support services to students. Learning Centres should be equipped to enable learners to have comfortable places to access reference texts, and learn, to reduce educational disadvantages existing in LMICs. Distance education holds the potential of making adult learners have access to education they need to develop themselves, and their economies (Author, 2017). Distance institutions recognise that distance education deficit requires forms of back-up apart from a text; called 'Student Support.' Simpson (2015) is of the view that this student support falls into three main areas- *cognitive, emotional,* and *organisational* qualities and skills. Distance education departments need to do the balancing act in supporting adult learners; not over-concentrating on the academic needs of adult learners, but their emotional and organisational skills to keep them focused on their studies.

Governments in LMICs should partner HEIs in providing adult learners' one laptop each; the degree of autonomy of adult learners in learning endeavours needs to be guaranteed. This could help speed up the digitisation process sweeping across the developing countries. Virtuality, or online learning, seems to be the order of the day. In fact, when Queens College in New York completed its "Five Presidential Goals" plan a few years ago, it identified *technology* as one of the critical elements in moving the college forward (The Economist Intelligence Unit, 2008). Hence Governments in LMICs, including Ghana must, by policy, start working in tandem with HEIs in their economies in providing one laptop each to adult learners. Thus, learning by distance education mode becomes more ubiquitous, and students take their examinations at home, and do more learning on wheels. Group learning appears critical in adult learning; hence, tutors of distance education programmes should be encouraging adult learners to learn in groups. Group learning is a long tradition of adult education (Imel, 1997) and (Brookfield, 2004), since adult learning thrives more on *dialogue* and *conversation* (Bryson, 2017). Learning in groups encourages the sharing of ideas and perspectives. The cross-fertilisation of ideas expressed during discussions aid adult learners, because no one head is a repository of all knowledge and wisdom. It takes two heads, or more, to learn and excel in HEIs. Adult learners are to be offered regular training to learn with the SAKAI (LMS) teaching and learning tools to ensure its sustainability. As adult learners research courses informally with their laptops at anytime, anywhere, and at their own convenience, they become more focused on their studies. Selwyn and Gorard (2004) note that once adult learners are comfortable with technology use and could search and filter through information on the Internet effectively, informal learning can explode. Adult learners must be encouraged to learn online, because that is the direction learning is taking us to.

Conclusions and recommendations

The paper summarized the wider context of distance learning. It employed assemblage theory as a framework in strengthening distance education delivery programmes in LMICs. The Ghanaian case study of distance education delivery was examined. It was done to bring into sharp focus the interrelated or co-functioning nature of HEIs, adult learners, and governments to work creatively together in delivering distance education. This demonstrates the importance of assemblage theory espoused by Manuel DeLanda. Distance education may be the future for LMICs, yet there are issues in relation to the modes of delivery to resolve to aid in student retention, success, and engagement. The point is that issues involved in the delivery of distance education are interrelated and intertwined. It calls for co-functioning of key stakeholders as assemblage theory indicated. Hence, key stakeholders involved must collaborate in surmounting challenges bedeviling distance learning delivery in LMICs. It also means that the digitisation process started by the Government of Ghana is stepped up. When this is done, there would be improved networking, high speed internet connectivity and WiFi installed on the campuses of universities in Ghana. This will aid in powering the one laptop to adult learners' proposal made. It also means that adult learners plan and manage their time well to learn anywhere, anytime, and at their own convenience. It is by this process that the *virtuality* in learning, which assemblage theory espoused, would be realised. Ghanaian universities are employing ICT teaching and learning tools, including the SAKAI (LMS) in delivering distance education to adult learners. However, many adult learners can learn to become digitally literate and self-directed to impact positively on productivity at workplace, and the economy of Ghana when payment of fees is made more flexible. The policy on fee payment should be

flexible against the background of unemployment and poverty confronting young adults and their parents.

The paper notes that the fast-paced advancement in ICT teaching and learning tools, and distance education provided by HEIs, is creating *access* to adult learners to learn. However, distance education can be strengthened to achieve the intended purpose when issues including lack of computers, deteriorating computer laboratories, lack of funding for learning, and students support services are resolved. Alongside the provision of one laptop each to a student, HEIs should judiciously use part of their internally generated funds (IGFs) to refurbish and retool the state-of-the art computer laboratories to give full meaning to virtual learning. This is important because research indicates that the implementation of e-learning in higher education has the potential to create more opportunities and raise the quality of education for a greater number of students. More so, adult learners with multiplicities of responsibilities can be motivated to learn and achieve lifelong learning dream when *students support services* are proactively provided to address their psychological, social, and educational needs or (cognitive, emotional, and organisational skills). Prof. Ormond Simpson in 2013, made a presentation at a workshop at the Institute of Continuing and Distance Education (ICDE), University of Ghana on the topic: *"Distance Education in Ghana,"* revealing that distance students need to possess certain requisite qualities and skills to succeed in their lifelong learning endeavours. He listed the qualities and skills as: intellectual ability, motivation to learn, ability to deal with stress, self-confidence as a learner, sense of humour, enjoyable time management and good 'learning' skills. These qualities and skills are critical because most students, according to Simpson (2008; 2015), who fail in distance education courses have poor emotional skills; hence provision of student support services are critical in adult learners' lifelong learning drive.

Thus, the capacities of students support services components in the Learning Centres are regularly built and equipped to work to the benefit of adult learners.

Faculty members at the Distance Education Department should be motivated, and capacities regularly built to become committed to work, and live up to delivering distance education. Regular orientations must be offered to tutors, examiners, and administrators of distance education programmes to become abreast with new developments taking place in distance education provision. Governments in LMICs must start partnering with HEIs in providing adult learners with a laptop each. Again, SLTF must be proactive in releasing funds to cushion *all* adult learners on their studies. The Government of Ghana should step up facilitating and partnering the private sector players to create job opportunities for young adult learners to work, earn, and learn at HEIs by distance education mode. With these policies as incentives, adult learners will learn their courses and take assessments at home. This initiative is important for LMICs that aspire to new levels of cultural, scientific, and technological development. The digital era makes it imperative for LMICs to fully buy into lifelong learning. Heredia, Carvalho and Viera (2019), and Paniagua and Simpson (2018) assert that democratic governments around the world are constantly investing in public policies and processes with a view to increasing, expanding, and democratising access to knowledge. This *flexibility* of learning, when vigorously promoted among adult learners, could serve as a *magnet* to attract young adults to aspire and take the initiative of learning in HEIs through the distance education mode.

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ACKNOWLEGEMENTS

Instructions to Authors

African Journal of Ageing Studies (AJAS) is a peer reviewed multidisciplinary journal, which will be launched in 2023 to provide new perspectives on the challenges of ageing, healthy ageing and increased life expectancy, aged policy dynamics, and quality of life. The editors believe that ageing is a process that affects humanity. It has become increasingly essential and must include improving the quality of life and the well-being of older adults. It should embrace the choices and opportunities that are available to older people.

This Journal seeks to encourage researchers and/or authors to think about keeping up to date in their respective fields and continue to integrate knowledge, research, both in terms of content and process particularly from multidisciplinary dimensions. Ageing and ageing care needs, preferences, strategies, and policy dynamics cut across economic, social, political, and psychological issues and spectrums.

The Journal will publish original works related to ageing that expand concepts, measurement tools and policy alternatives. It will provide a platform for an open exchange of ideas among a wide range of scholars, policy makers, economists, researchers, academics, and other experts in the field of ageing.

The African Journal of Ageing Studies will provide a platform for alternative ageing approaches and the Journal will act as a channel for members and critics of this school. It will emphasize originality on African perspectives on ageing and future directions in Research, Practice, and Policy, which would in turn necessitate the direction of future change in the issues of ageing at large.

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Details concerning the preparation and submission of manuscripts can be found on the inside of the journal.

Article types

The journal will consider the following article types:

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Research articles should present the results of an original research study. These manuscripts should describe how the research project was conducted and provide a thorough analysis of the results of the project. Systematic reviews may be submitted as research articles.

Reviews

A review article provides an overview of the published literature in a particular subject area.

Notes for contributors

Manuscript submission

Manuscripts between 5000 and 8000 words, should be sent to the editors. The manuscripts should be in electronic format (as a Word document) and be sent by email. The manuscript must be double-spaced, with ample margins and contain the title of the contribution. The manuscripts must be numbered. Footnotes to the manuscript must be kept to a minimum.

Terms of submission

Manuscripts must be submitted on the understanding that they have not been published elsewhere and are only being considered

by this Journal. The submitting author is responsible for ensuring that publication of the article has been approved by all the other co-authors. It is also the submitting author's responsibility to ensure that the article has attained all the requisite approvals.

Contributors must keep in mind the fact that they are addressing a variety of audiences of academics, policymakers, ageing experts, and practitioners. Where possible, jargons should be avoided whilst the choices of terms must be defined.

Title and Authorship Information

A separate document should contain the names of the authors, the title of the contribution including the addresses where the research was carried out. The following information should be included:

- Manuscript title
- Full author names
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Full postal addresses and email addresses of the corresponding authors must be provided. The corresponding author will if accepted, check proofs and receive correspondence. Each article should be accompanied by a brief note of biographical details of authors.

Abstract

The manuscript should contain an abstract. Each article should have an abstract/summary of 250 words. The abstract should be citation-free.

Introduction

This section should be succinct, with or without subheadings.

Materials and Methods

The methods' section should provide enough detail for others to be able to replicate the study. If you have more than one method, use subsections with relevant headings, e.g., different models, in vitro and in vivo studies, statistics, materials, and reagents, etc.

If a method or techniques is introduced in the study, including software, questionnaires, and scales, the license, available under any requirement for permission for use should be stated. If an existing method or tool is used in the research, the authors are responsible for checking the license and obtaining any necessary permission. If permission is required, a statement confirming permission that was granted should be included in the Materials and Methods' section.

Results

This section may be divided into subsections or may be combined.

Tables, figures, and captions to illustrations should be completely understandable, independent of the text. Tables and figures must be on separate pages and their exact positions should be indicated in the manuscript. Tables must be numbered by Roman numerals and figures by Arabic numerals. Please provide clear copies of figures that cannot be transmitted electronically, in a format suitable for reproduction.

Discussion

This section may also be divided into subsections or may be combined. Further, this section should intersperse the findings with existing empirical evidence.

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This section may be divided into subsections or may be combined.

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This should clearly explain the main conclusions of the article, highlighting its importance and relevance.

Language

Spellings in English (United States version) language is preferred.

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